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Planning Emergency Treatment Services for Comprehensive Community Mental Health Centers.

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Proceedings of a conference designed to bring together persons interested in the operation of Suicide Prevention Programs and Comprehensive Community Mental Health Centers are reported. Content addresses deal with the following: (1) total emergency programs; (2) emergency service as an alternate to hospitalization; (3) the utilization of non-professional workers; (4) a community approach to crisis intervention; (5) inter- and intra-community coordination of services; (6) social and political dimensions of psychiatric emergencies; (7) suicide as a health and social problem, and (8) new direction for suicide prevention services. A total of six task oriented groups demonstrated what tends to happen in the real-life planning of community mental health services. Like communities, some groups failed while others were successful in their task. (Author/EK)

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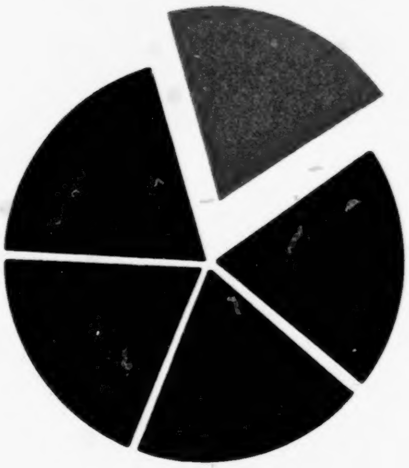
PLANNING EMERGENCY SERVICES FOR...COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS



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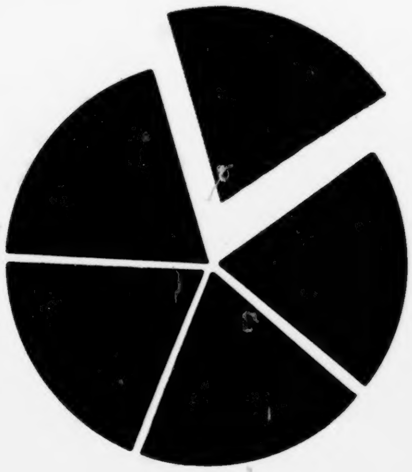
Planning Emergency Treatment Services for...

Comprehensive Community Mental Health Centers



Conference Proceedings

edited by
Richard K. McGee

foreword by
Martin Kramer

University of Florida
Gainesville, Florida
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THESE PROCEEDINGS ARE DEDICATED

TO

LOUIS I. DUBLIN

for having championed the development of suicide prevention programs in this country for over three decades,

for giving untiring leadership and inspiration to those who have taken on the task, and

for being a very dear friend.

FOREWORD

I am here because I have some questions to which I would like answers, or at least partial answers, and I suspect that is also why a lot of you are here. Let me tell you what some of my questions are and see how they coincide with yours.

My first question is: "What is it to plan for emergency services?" When I say this I really have in mind two different concepts of planning. One is "contingency planning", which we all tend to associate with foreign relations and military crises. This is planning for a highly specified sort of event, e.g., what if Country A attacks Country B and draws the United States into the conflict? What do we do then? You can also envision that kind of planning for psychiatric emergencies. Suppose that in a certain family, in a certain part of the city, something happens that requires psychiatric expertise--action by the mental health service system. What do we do then?

The other kind of planning is "resources planning", or the planning which enables us to have on hand those resources we will need to deal with a wide range of crises. We are not saying exactly what sort of crisis it is going to be, but we try to be ready for anything. Which kind of planning is it that we are most concerned with here?

One of the things about contingency planning is that it is relatively cheap. If, in fact, you know just what you are planning for with some precision, you can plan for it fairly cheaply. On the other hand, contingency planning does not allow us to hedge our bets. Resource planning does, and that is its great advantage. This distinction may extend over into attitudes of treatment personnel, too. Mental health personnel who are not prepared to participate in an emergency service sometimes seem to think that there must be a contingency plan for everything that happens. There can be a sense of panic and betrayal, if not among the professionals in the community, then among the citizens of the community, if there cannot in fact be such contingency planning for every crisis.

Another question I want to ask is: "What is the relationship of emergency services to the preventive services of the center?" People are inclined to see these two programs as fairly remote ends of a spectrum. Emergency services are viewed as those things which you do in a hurry, and preventive services are viewed as those activities which you undertake in perhaps the most leisurely way of all. But I think there are some relationships--at least there are some conceptual ones--behind my question. Do we have emergency services precisely because we don't know how to prevent psychiatric illness? There is probably something to that. On the other hand, maybe it is true that intervention must be on an emergency basis even if we do know a fair amount about prevention. But what about the future? Suppose we gain new knowledge which enables us to prevent psychiatric emergencies of given kinds? How is that going to change the function of the psychiatric emergency service? Well, considerably. As we develop both conceptual and therapeutic understanding of those things which bring people to crises, then the way we handle crisis and the point of our intervention must inevitably change.

Let me also raise the question: "How does the emergency service affect total program planning?" How does it affect the other four essential elements of service? Clearly, the functions of the emergency service are going to influence some roles in the overall center program. The home visiting service, for example, is going to be radically different if it is viewed as an arm of the emergency service for crisis intervention, or if it is regarded more in the line of a rehabilitation activity. Surely all of your services are going to be influenced if you make it your overriding goal to avoid hospitalization; they will be staffed and programmed accordingly.

In some respects, a lack of planning will have many of the effects of planning itself. That is to say, the manner in which the emergency service makes disposition of its patients at intake will radically affect caseloads in all the other services. The kind of patients, the number of patients will be affected. As a direct result of the functioning of the emergency service, various kinds of programming within other services will be either feasible or not feasible, desirable for the usual patients in a given service or not desirable. An emergency service can actually control the conceptual basis of the treatment program by influencing what becomes realistic and what seems unrealistic in the other services.

It is very important to consider: "How will the emergency service affect community thinking about the needs for mental health services in the community as a whole?" The very existence of the emergency service strengthens the idea of community competence, and by so doing makes perhaps the largest single contribution to the community's image of itself as the locus of mental health care. But we ought to ask whether or not the emergency service, if located in the general hospital, overemphasizes the medical model and a medical attitude towards the needs and capacities of the mental patients? Will it suggest that a mental patient is helpless to make a lot of choices which a physically ill patient might indeed be helpless to make? Will it suggest to the community that the emergency service is the normal point of entry into the community's system of care? That would indeed be unfortunate.

Finally, "How will we budget for emergency services?" Primarily, from the applications we are seeing, the emergency services of Comprehensive Community Mental Health Centers are going to have very short rosters of staff indeed. The roster will be small and the line item budget will be small. But I think all of us here know that while the emergency service can, in a sense, be the cheapest service, it can also be the most expensive service--expensive both in the pattern for the utilization of other services which it establishes willy-nilly, and also in terms of the cost of disability which inadequate emergency dispositions can cause. Thus, it is a key service in the mental health center that we are concerned with when we plan for emergency programs.

A way of making this point occurs to me: Suppose you were suddenly the director of a Comprehensive Community Mental Health Center and you really wanted to get hold of the total program, to understand its direction, and to get some leverage on it. You could not do better than to start with the emergency service, reconsider its rationale and develop its staff and its program.

Martin A. Kramer, Ph.D.

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INTRODUCTION

The significance of a Workshop on the planning of emergency mental health services is partly revealed in the events of the past thirteen months. The planning for this conference began in November, 1966. At that time there were twenty Comprehensive Community Mental Health Center grants awarded to cities in the States of Mississippi, Alabama, Tennessee, Georgia, South Carolina, and Florida which comprise Region IV of the United States Public Health Service. There were ten communities in the Region in which suicide prevention centers had been established, or were being developed by active planning committees.

By the time the Workshop was held in September, 1967, the number of Comprehensive Community Mental Health Center grants in the Region had reached thirty-three, and the number of suicide prevention programs had grown to fourteen. In ten months, the rate of program development in the Southeast--and throughout the country--had proven to be fantastic.

This is surely no time for hasty, haphazard experimentation. Neither is it an era which can tolerate the proliferation of perfunctory, routine services because it is expedient to work only within the comfort of those concepts and procedures which are well known. It is a time which demands careful, deliberate, albeit tedious, planning for organized change and controlled innovation. It was within this context that the Workshop Program was planned. Its purpose was stated:

> . . . to bring together the leaders, directors, and other responsible persons already involved, or about to become involved, in the operation of Suicide Prevention Programs and Comprehensive Community Mental Health Centers, and to stimulate them to think and plan together for the integration of their services towards the accomplishment of their common goal.

The specific objectives of the Workshop were drawn from the fact that there have been these two major developments in emergency services for persons in states of emotional stress and/or psychological crisis--the Comprehensive Community Mental Health Center, with its required 24-hour emergency service; and the suicide prevention center, with its 24-hour telephone and trained crisis intervention team. The development of each type of service will, and must, continue. They are mutually dependent upon one another; optimal efficiency of either demands the presence and cooperation of the other.

It may be very simple to develop an emergency mental health service, especially if the comprehensive center is to be planted in a general hospital setting. What is more familiar to a hospital than an emergency room, or emergency admission to in-patient status? With the development of psychiatric in-patient units, it should be a simple procedural matter to arrange for admission to such facilities from the emergency room, even "after hours". If the walk-in clinic is attached to the out-patient service, as it appears may happen most places, there will be little left for the emergency program to provide--unless, of course, there is a desire to add the innovative, creative, and imaginative spirit that can turn an acceptable plan into a truly first-class community health program.

The suicide prevention programs developing around the nation have already been embracing the innovative attitude in their manpower, their clinical procedures, and their broad community focus. Much has been learned as a result of their still short life span in the field of emergency service, but there is still more to be learned about crisis intervention from this type of agency.

Thus, there were three major concerns woven into the fabric of this Workshop Program. These concerns were (1) that the new Comprehensive Community Mental Health Centers plan to provide complete emergency service, with especially competent crisis intervention and suicide prevention programs; (2) that the suicide prevention centers continue to develop throughout the nation, as a result of direct promotion by state mental health authorities as a first step toward the development of full scale crisis intervention and emergency services; and (3) that existing suicide prevention programs and the new comprehensive centers work in a cooperative, collaborative, and perhaps even consolidated manner.

To achieve the objectives of the Workshop, the format of the program was kept simple and straightforward. In order to present all sides of as many issues as possible, the input or content addresses were followed by planned reactions. This was designed to allow friendly colleagues the opportunity to disagree with one another in a constructive fashion. The Workshop Task Groups were organized around six partially over-lapping problem areas. They were charged with the responsibility of exploring one major question, and a set of corollary questions, and then they were to formulate a report to the conference.

It was not expected that any final plans were to be drawn up by these groups. It was only an optimistic hope that some recommendations might be generated to serve as guidelines for the job to be done in the local communities. But, at the very least--and this is not to be discounted--the program provided the opportunity, and the challenge, for people who have something to learn from one another to sit down together and confront some crucial issues.

That objective was accomplished. It was accomplished in a manner that was a genuine satisfaction to those who planned and sponsored the conference. It was considered an unqualified success by most of those who attended. Yet, the value of this meeting can only be determined by the extent to which the material provided in these pages finds its way into the actual planning and operation of emergency services.

The collective experience, knowledge, faith, and concern of sixteen contributors and over one hundred participants have been assembled, and are herewith submitted to the community of mental health program planners with a most sincere wish for Godspeed in the task which lies ahead.

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PART I

CONTENT ADDRESS AND REACTIONS

AN INNOVATIVE BLUEPRINT FOR A TOTAL EMERGENCY PROGRAM

Harold L. McPheeters

General Issues

Before moving to any specific program proposal, it might be well to look at some of the considerations that surround emergency mental health services. The prime issue concerns the very notion of emergency. The line that one draws as to what is and what is not an emergency may vary from that situation in which a person is seriously threatening his own or someone else's life, to situations that most of us would consider to be only urgent, or perhaps even routine, with an overlay of anxiety on the part of a family member or an agency.

Definitions of "Emergency"

I remember when I was interning, one of my first psychiatric "emergencies" came about 4:30 one morning. I was called down to the emergency room. There was a seventeen-year-old girl who was practically comatose, with a strong smell of alcohol, and a very irate father. The girl had gone out on her first date with a boy, who brought her home about 4:00 in the morning so drunk she did not even know which house she lived in. She got out of the car a couple of doors up the street, staggered up to the porch and collapsed on her own front porch. The father found her and brought her to the emergency room, where he wanted her psychoanalyzed at once "to find out what she had been doing with that s.o.b." So, even psychoanalysts, I guess, have emergencies. The patient, of course, was delightfully tranquilized; there was no problem with her.

At the other extreme, however, we have patients dead on arrival, or with extreme physical injuries from a suicide attempt; or people in fugue states, paranoid reactions, rages, and acute psychotic reactions of other kinds.

It seems to me that mental health professionals and their agencies have been inclined to make very restrictive definitions of which persons they consider to be emotionally disturbed, and particularly which ones they consider to be emergencies; they very rigidly define the conditions under which they will treat emergency cases. I am afraid that this is usually done in the context of what the staff feels most competent and comfortable in doing, rather than in what the person needs.

However, I think society has its own way of defining emotional disorders. Essentially, society's definition evolves around the notion that any person is sick if he behaves very differently from the way most people would behave in any given situation. When this happens, society becomes anxious and wants help from its behavioral specialists--the mental health professionals. Society does not care whether the behavior results from psychosis, as we define it, or psychoneurosis, as we narrowly define it, or whether it is from a sociopathic personality, or the result of a delirium, or whether it is an epileptic equivalency state; but society wants help now. Society doesn't want us to say, "This is an epileptic patient who should go to the neurological clinic," or "This is a sociopathic personality; it should be handled in the context of the courts."

Yet most of our emergency services that presently exist--and this is particularly true of the suicide prevention services--are set up almost entirely for the individual who becomes anxious enough within himself to come seeking help. Referrals by other agencies are almost resented.

The Emergency May be a Group Problem

Someone has pointed out that psychiatric referrals may come from three kinds of pressures. First, aggressive, destructive behavior for which society as a whole demands help; second, bizarre or unusual but not dangerous behavior for which some family or some agency is seeking help; and third, disturbed feelings perhaps with no behavioral manifestations, but for which individuals come seeking help. Our emergency services--and I am afraid, often all of our services--have too often been structured only for this third group, the person who feels the need within himself whether or not he has any behavioral problem, and who comes on his own, seeking the service. If we are to be of the greatest service to our entire community, we must seek out ways to meet the emergency needs of the greater society when it feels the pressure, *and not just at our convenience*.

A major factor involved in emergency service is the reality that there is always some degree of crisis and attendant anxiety. This is true whether the patient is an individual who has become anxious enough to seek help for himself, or whether it is a family or an agency, or even the society at large which is seeking help for a disturbed member. Gerald Caplan has written much about crisis intervention in the individual, but do not the same principles of growth from crises apply in regard to families, agencies, and even the total society when they are in crisis? Will they not also grow in maturity and understanding as the result of some effective, knowledgeable assistance in time of crisis? I believe that they will.

If, in community mental health programs, we assume that the community is our patient, then our entire catchment area and the maintenance of its mental health is our concern, and we must structure our services so that we are available to meet the anxiety of mental health crises from any caller, whether it be society as a whole, a specific agency, a specific family, or a single individual.

Emergency Requests are Irrational

In meeting emergency requests from families and agencies we sometimes become impatient because in our opinion their requests are irrational. For instance, we become annoyed if they ask that a patient be put in the hospital when he does not need to be in the hospital. Yet we seem to be quite tolerant of similar irrational requests when they come from individuals. We seem to feel that the individual may have a right to be irrational. We must keep before us an awareness that in the face of disturbing behavior, anyone may become anxious and unrealistic. Even psychiatrists and psychologists become irrational in the face of an emergency psychiatric crisis in their own families or their immediate friends. Extremely intelligent people and agencies can become very irrational about the way they handle emotional crises.

As professionals we must be available to answer the cry for help in some effective way, no matter from whence it comes, although the help may not always be in the terms in which it is requested. This is a key point to keep in mind: _Very frequently the requests are irrational, but it is our responsibility to find some effective way to meet these needs, although it may not be exactly what is originally asked._

Emergency Service as a Form of Primary Prevention

If Caplan's notions about using the anxiety of a crisis to mobilize effective learning and emotional growth are valid for families and agencies as well as for individuals, then we would expect mental health programs to seize on emergency services to the community at large as an effective way to enhance the overall mental health to the community. Obviously, this will involve more than just relieving the crisis on a symptomatic basis. Thus our program structure for emergency services should provide for growth-inducing consultation at the time of the crisis, in addition to relieving the immediate emotional stress.

It seems to me the nature of emergencies offers still another specific opportunity in the area of prevention. The crisis which leads to the emergency call is very likely to follow very closely on the event or situation which precipitated the anxiety. Thus, I think if we keep sufficiently systematic records of our experience, our series of emergency calls, we should be able to discern patterns of precipitating stresses or events which lead to certain kinds of crises. It may then be possible to plan strategies of intervention for target groups of persons who are found to be in jeopardy of certain kinds of crises in our community, in order to head them off. This permits a program of true primary prevention. As I see it, the only approach to primary prevention is, first of all, to keep adequate records of our clinical experience. They must be the kind of records that enable us to analyze our clinical work, then to find individuals who seem to be in jeopardy by virtue of their clinical history, to plan a point of intervention, to organize a strategy of intervention and then to measure change in the incidence of crises. As an example, some years ago I was engaged in consultation with medical students. Among the problems I saw the first couple of years were the students who came in about November of the freshman year because they were failing academically. These fellows were married and had left their wives back home. They were going back and forth every weekend, worrying about her and the children. All of this worry and travel was leading to their academic failure. After observing this pattern, I began to meet with all the freshmen sometime during the first week of classes and talk to them about some of the kinds of problems I saw students encountering. I would tell them about this problem of separation from a wife back home, and I would recommend that they move their families to the city in which the medical school was located. After I started doing this, I never saw another student with this problem. This is an example of examining your clinical experience, then planning strategy of intervention and measuring your effect afterwards.

This method of primary prevention of various kinds of emotional disorders would find a natural application in an emergency service. In fact, it is unlikely that there is any better way to clinically determine the specific target groups of persons in jeopardy and the specific stresses in any particular community than to provide a readily available, accessible and well publicized emergency service in that community.

Emergency Service as a Form of Secondary Prevention

Furthermore, such an emergency service may offer two other important aspects of prevention, both in regard to secondary prevention or early case detection and management. One aspect involves preventing the natural, social and psychological complications that will result if certain conditions are allowed to continue without any intervention. For example, a school phobia, if it is not relieved almost immediately, often leads to academic failure and a school dropout, whereas if such cases are seen immediately, they might have been remedied. In fact, I would recommend that a comprehensive community mental health center, or at least some substantial portion of that clinic, stop all treatment services of regular clients for the first week of school and take care of school phobia cases on a systematic emergency basis until this problem is resolved.

The other aspect of secondary prevention that may result from an available, accessible and well publicized emergency service, is that it may prevent some conditions from worsening to the point where some psychiatric or social tragedy would result. This, of course, is the basic premise upon which suicide prevention services are established, but there is also evidence that incidents of homicide, assaults, and destruction resulting from unequivocal emotional disorders are reduced when psychiatric services are readily available in the community. Families and agencies apparently are aware of the increasing disturbance of these persons, but so often either the families lack knowledge of resources, or the resources are so restricted or so unavailable that the family postpones seeking help until after the tragedy occurs.

Specific Types of Psychiatric Emergencies

Having discussed these general issues, our next step in outlining emergency services is to examine the kinds of specific problems which are frequently presented as psychiatric emergencies.

Desperation

Perhaps the one that is best known to persons who presently engage in emergency work, in suicide prevention services, and in other services in which the individual is expected to seek help for himself, is the feeling of desperation. This is the most common precursor of suicide. Regardless of the clinical syndrome with which we would diagnose this person's problem--whether he is depressed, schizophrenic, or something else--and regardless of his specific social and psychological stresses present, the individual feels desperate and is likely to cry for help when he knows that there is likely to be some help available.

Anxiety

Another problem that may lead to an emergency is overwhelming anxiety, whether or not the person himself feels desperate. This may manifest itself in acute anxiety reactions, panic states, various kinds of conversion reactions, and incipient deliria; but the essential problem is one of overwhelming anxiety.

Acute Confusion

There are some things that tend to lie more in the medical than the psychological area, for example, the problem of acute confusion. This problem might be divided into the "organic" confusional states, the deliria, epileptic states, and other acute cerebral dysfunctional conditions, and the "functional" conditions such as catatonic states, amnesias, stupors, etc. While these are usually qualitatively somewhat different, they both result in a kind of confusion that may lead the family or someone else to bring the patient into the emergency service.

Acting Out

A final major problem is the propensity to act out in some antisocial, aggressive or destructive way. This is the condition against which society as a whole feels the greatest need for protection and for which it has provided police, mental hospitals, etc. Most often this state is reached only after the individual has had some combination of desperation, anxiety and confusion. I suppose the sociopathic personality is an exception to this notion. In his Introductory Statement, Dr. Kramer pointed out, and I would certainly agree, that if you had a service which recognized the first three conditions, you would have many fewer cases coming to the point of acting out, and so the strategy, or the form of intervention, would change in time.

Emergency Consultation to Agencies

Nearly all psychiatric emergencies for which individuals present themselves are brought to our attention as the result of some combination of these four elements. Occasionally a person is brought in simply because the family's tolerance for his behavior has been exceeded. Such occasions seem to occur mainly in persons who have previously been hospitalized for mental illness, and more conscientious and aggressive after-care programs could have prevented many of these cases from becoming emergencies. We must remember that in many instances of psychiatric emergency, it will be an agency or the family, rather than the individual himself, who appreciates the fact that the patient needs help. Very often the individual himself may not need to be seen, if consultation can be offered to the family, or to an agency, or to someone such as the family physician who happens to have the primary responsibility for the person. However, even this kind of emergency consultation must be readily available, accessible and well known.

In this matter of consultation to agencies, it may be hard to imagine emergencies other than case emergencies; but other situations can arise, and these will often be very unique requests for emergency consultations. We must keep in mind that all emergencies are in some way unique, and we must keep our operation flexible enough to meet whatever comes. The police are especially likely to request emergency consultation--for instance, regarding potential riots, or unusual crimes. I once had a police department official call and say, "We have had several calls to a grocer's daughter--obscene, threatening calls. We have traced out all the calls, the kinds of things he said, the kind of conditions, etc., and we are stumped. Do you have any idea what kind of person we are looking for?" Of course, this kind of request must be answered at once--not in a week or so.

Considerations for Treating Emergency Cases

Let us look at the kind of services that are required in order to meet these various emergencies.

1. The first requirement is for a warm, empathic, yet dispassionate examination of the problem. Acceptance and listening alone may dissipate much of the anxiety and desperation, and offer a great deal of reassurance.

2. Next, some specific questions about the onset, background, etc., may be necessary for proper assessment of the problem.

3. Sometimes a brief mental status exam, or a physical exam, is in order.

4. Gradually we get into things that require more specialization. Generally these last two procedures (mental status or physical examination) should be done with a patient alone, away from his anxious family or the police.

5. For anxiety and desperation, simple supportive measures such as reassurance, generalizing the problem, or perhaps some advice for action, may be most helpful, and may be all that is necessary.

6. For confusion and acting out, some kind of special supervision, even hospitalization, may be recommended and arranged.

7. Finally, medication, a step that should stay with the medical field, may be desirable.

All of these steps, whatever is indicated, may be sufficient to stop what I call the "psychological hemorrhage," or the crisis of the moment. They should certainly be applied as indicated. On the other hand, a palliative effort alone should not be our goal. A community or person will achieve a degree of emotional growth as a result of simply surviving a crisis, and we should keep this in mind in planning emergency services. But we should be able to offer more than just the palliative in order that the person or agency will have a greater chance to keep on growing, and learning to cope with future crises, if not to avoid them altogether.

Referral to Other Services

In many settings nearly all persons who are seen in the emergency service are referred for subsequent treatment elsewhere in the program. Certainly, this is appropriate in many situations. Hopefully, one result of any treatment the person receives will serve to prevent his having another emergency crisis. However, referral into immediate treatment is not always feasible, and it may not always be desirable. In the District of Columbia emergency program, 24 percent of the cases are not referred at all. Such a finding leads us to ask, "Are there ways in which we can use the emergency consultation itself to foster growth and to prevent recurrences? Is it possible that families, or referral agencies, or even the patient himself, be given advice or encouragement to consider ways in which his feelings or the events themselves might be handled more effectively in similar situations in the future?" I would submit that this is possible. In fact, it may be particularly effective when the anxiety of the crisis has strengthened everyone's motivation for exploration and learning. With conscious planning, the emergency service can become a potent agent for prevention, and for mental health education for agencies, families, and even for the patients themselves.

Innovative Organization of Emergency Services

Administration

How, then, would we structure and operate our emergency service? First, it seems to me that the emergency service must be recognized as a specialized component of the comprehensive community mental health program. It should be given adequate direction by a fully qualified mental health professional, and I don't have any preference for any particular discipline. The direction needed is not just a matter of having a call roster with someone available to answer calls at any time. Rather, the director of an organized service must be someone who can plan it, stay on top of it, and really run it. The service must have its own staff, its own goals, its own system of record keeping. The staff, even the director, may have other responsibilities in a small program, but still the emergency service must be sufficiently discrete to be recognized as a separate function. It must be visibly responsible, I would hope, for both emergency services and for programs of prevention.

Manpower

The service may have volunteers to answer calls or it may depend entirely on professionals or new kinds of middle level mental health workers. Certainly, volunteers can do a splendid job of answering the cry for help after proper training and supervision and with consultative backup by professionals. The same has been found to be true of middle level workers.

Home Visits

The staff may make home calls or not; I think there is a genuine advantage to seeing a person in a situation firsthand in the original setting. But home visits are also time-consuming and expensive. A few years ago I had the privilege of riding with the radio car in Amsterdam, in the Netherlands, in their emergency home service. And even though I spoke no Dutch, I am sure I understood far better what was going on in those family situations by being there in the home. If the staff is available, for example, in a teaching center, home calls should be provided around the clock. Otherwise, I would still recommend that the staff make some home visits whenever their schedules make it feasible. There is no better way to know the problems your community presents.

Availability of Service

The emergency service should be readily available and readily accessible. Telephone callers or persons who walk in should be served immediately or surely within a couple of hours. There should be arrangements for accepting long distance calls collect, and even paying taxi fares for people who come in. The service should be physically accessible, of course, but even more, it should be socially accessible to all ages, all races, all economic groups, all agencies, all diagnostic groups, etc. Not only should the service be available and accessible, but also it should encourage utilization. This requires that the emergency service be well publicized to community agencies, and to the public at large. This will mean newspaper publicity, which mental health people tend to shy away from. Special promotion should be directed to groups, such as police, physicians, health officers, public health nurses.

Telephone Service

I sometimes wonder what kind of telephone service may become most feasible in large urban communities where there may be three, four or more mental health centers. In Philadelphia, for example, where they have the city pretty well covered now with either construction or staffing grants--what kind of program will we have there? Will each catchment area have its own telephone number, or will there be one number for Philadelphia? To avoid confusion, it may be well to consolidate the whole answering service for a community. In some of the less populous States, it might be better to have a single emergency number for all the State. When I was Commissioner in Kentucky, I seriously considered having a single number which people could call from any place in the State. Obviously we could not have made a referral of every single call to a community mental health center, but even the telephone alone would make it worthwhile, for a substantial number of people.

Staff Roles

The staff should see their task as much broader than merely offering a palliative, stopping the crisis of the moment. They must actively find ways to help the individual and agencies to use the present crisis so that they can manage future crises, or avoid them altogether. Perhaps the techniques for doing this may need to be specifically planned for each case. But this should be kept in mind as a goal or it will seldom, if ever, be done. Furthermore, it is likely that after some experience, general guidelines will be developed for certain kinds of cases.

Use of Other Agencies

The emergency service must have either the ability to refer patients to other parts of the mental health center--outpatient service, inpatient service, etc.--or else the emergency service must have the staff and the time to counsel with individuals themselves on a more prolonged treatment basis. One question that has been raised in relation to some of these emergencies--particularly alcoholism, hallucinosis and suicide attempt which may have medical components--is whether these people should be admitted to a medical service or to a psychiatric service. My preference personally would be strongly in favor of a psychiatric service as soon as possible. Any standard operating procedure which admits all alcoholics to the medical ward for five days or so is going to lose a tremendous therapeutic advantage in the psychological area. The emergency service needs to be especially knowledgeable about other community agencies and resources, both for referral and to be able to offer appropriate emergency consultation when requests come from these same agencies.

Case Records

The emergency service must plan to keep a different kind of record, in addition to the usual case folder. These would be the records to be used in evaluation of the emergency service and for planning the preventive program. These records would be more akin to the disease registers of some general hospitals than to traditional medical records. From them the staff could make studies of certain kinds of emergencies by age, sex, place, time or whatever other data seem to be significant in planning a program, or for evaluation of the operation. This would require some rather careful planning for the type of information to be kept, but it is not possible to go back to traditional case folders for this kind of research and evaluation. The staff, particularly the director, should also have responsibility for doing these kinds of analyses and studies, and then implementing appropriate strategies of prevention. While these records are being kept on a continuing basis they will provide a substantial base for evaluation for a preventive program and for the emergency service itself. Of course, evaluation is one of the things we all talk about, but here is a chance to make the record doubly useful, both for evaluation and prevention.

Education Programs for Prevention

In many mental health centers it would be well to give full responsibility for all prevention and mental health promotional services to the director of the emergency service. These should certainly be closely related. This would be especially appropriate in those centers where prevention and

Summary

These are some of the notions I would structure into a functional emergency service. It obviously includes far more than the usual 24-hour telephone or 24-hour walk-in consultation service. Perhaps it is too much. However, it appears to be one way to make the mental health center immediately useful and sensitive to the community's crises. But most of all, this kind of a service would provide the long-talked-about means for a systematic primary prevention program.

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Reaction to Dr. McPheeters

Thomas S. Ray

Dr. McPheeters has, indeed, suggested "innovative" program possibilities. Not only that, he has analyzed the relevant issues in a manner which helps set goals, considers problem categories, and provides a program blueprint regarding emergency mental health services, which, after all, is one of the five essential services in the new Community Mental Health Centers Act.

The approach described suits my way of thinking very well. I can not really offer any suggestions which would improve the plan in any important way. Further, with the progress being made toward implementation of the new Comprehensive Community Mental Health Centers, such conceptual organization is needed and helpful.

There are other solutions which have merit, depending on local circumstances, but I shall not offer a series of alternatives. The participants in this Conference will, I am sure, develop many elaborations and variations on the theme.

What may be important to consider is some of the problems which may stand in the way of establishing sound emergency service programming and implementation.

One of the greatest barriers to attaining even minimally satisfactory mental health services of any kind is that of professional manpower shortages and traditional conceptions of staffing patterns and manpower utilization. We are promising to implement the Community Mental Health Centers Act in addition to continuing to operate and expand the existing mental health facilities. But, so far as I can tell, there will be no equally great increase in professional manpower production.

We have been studying the problem at the Florida mental health offices in Tallahassee. It has been determined that the professional staffs of the mental hospitals are seriously depleted and that the community clinics have growing staffing needs as well. We have projected the added manpower needs for both the existing and planned new Community Mental Health facilities for the next five years in order to get an approximate idea of the manpower situation. In all, we see the need for the following added personnel by 1972:

Psychiatrists	201
Psychologists	174
Social Workers	312
Nurses	1180

These estimates are for agencies related to the Division of Mental Health only. They do not include the needs of other health and social agencies nor do they consider the numbers of professionals which will be absorbed in private practice and university programs.

We hope to obtain some studied estimates of proposed manpower production by university professional and graduate training programs against which these future manpower needs can be compared. It is an educated guess, at this point in time, that the overall supply will fall far short of the overall need. Furthermore, this is a nation-wide problem. We cannot expect a great windfall from the manpower supply of other states.

There will be an increasing premium on the services of the traditional professionals as the manpower supply falls further behind the manpower demand.

Reasonable men would look for different forms of manpower utilization--and they are. Harold McPheeters is a notable proponent of the production of new types of manpower and there are others, some of whom are present at this Conference. Yet, out in the community of professionals there is presently a massive indifference to the idea of developing new kinds of manpower. I suspect that pockets of active hostility may develop should matters evolve to the point that such manpower is actually produced.

The use of new types of manpower such as "middle level" mental health personnel and even the expanded use of volunteers is problematic. Resistance to the use of new types of personnel is to a large extent based on the desire to maintain status by professional groups, among other reasons. Real as these are, I tend to discount them as not entirely reasonable since they relate to the perceived needs of the professional establishment rather than the needs of society.

The problem which does bother me is that of the allocation of roles. As I think about it, it seems to me that historically, new professions have emerged in service areas which were not properly covered by the existing system. A case in point is the use of volunteers in the area of suicide prevention. This is a central issue in the present Conference. The theme of suicide prevention as a program is already identified with the innovating use of volunteers. This innovation could happen only because of an existing void of such services by professional groups.

The use of volunteers is, in general, not objectionable. What bothers me is that in the total spectrum of mental health services, the areas of crisis intervention, emergency services, and suicide prevention are the most dramatic scenes. Here is where the most competent and well trained professional should muster his greatest judgment and skill. These are areas of work in which our knowledge is often uncertain and in which considerable professional experience may be needed to cut through anxiety, confusion, and panic.

It seems to me that a thoughtful analysis might lead to the conclusion that the best trained persons should deal with crises and that lesser trained persons and volunteers should be assigned more sheltered roles like those in which the classical professional groups are now entrenched. Roles could be assigned to the volunteers in which they can learn by their mistakes without a crisis atmosphere, and in situations where their judgments are not so final as they can be in crisis situations.

In summary and conclusion, I think Dr. McPheeters has developed an excellent analysis of the problem and has made sound suggestions about an innovative program for comprehensive emergency services. I have described misgivings about the outlook for implementing such a program. Shortages of classical types of mental health professionals should lead to a program of redeployment of all kinds of personnel including new types with shorter periods of training, as well as volunteers. Thoughtful analysis should lead to the assignment of the best trained and most experienced personnel to the crisis arena.

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A COMPREHENSIVE EMERGENCY SERVICE AS AN ALTERNATIVE TO HOSPITALIZATION

Frank S. Pittman III

After arriving at this Workshop, I concluded, from my discussions with various people who were also involved on the program, that the general concensus was so close to my own feelings about crisis work and about the importance of making a distinction between treatment, as opposed to hospitalization--a highly important distinction--that I would really be quite at a loss for anything controversial to contribute. Fortunately, I was provided with an introduction by some of Dr. McPheeters' comments, and some of Dr. Ray's as well. We all talk about crisis work, and about individualizing our approaches. Yet we just heard Dr. McPheeters making what was really a passing comment that the alcoholic should be hospitalized in the psychiatric, instead of the medical hospital, although there did not seem to be a great deal of agonizing over whether the particular alcoholic, or for that matter any alcoholic, needed hospitalization at all. Then Dr. Ray described the unfortunate case of the woman who became catatonic, and whose crisis was resolved by hospitalizing her. So I think even among those of us who are very much dedicated to responding to the crises our patients are facing, there is still this tendency to fall back on the very familiar and safe psychiatric hospital.

Until recently, the mental hospital has been considered unquestionably the most appropriate, perhaps the only possible, setting for the treatment or confinement of seriously disturbed mental patients. Keeping such patients out of these institutions would have been considered dangerous and inhumane, if it had been considered at all. The only alternative seemed to be the family attic. Times have certainly changed! Even though keeping psychiatric patients out of psychiatric hospitals could hardly be considered a universal goal of psychiatrists, there is a growing appreciation that hospitalization need not accompany treatment, even for the most psychotic patients, and there is an ever widening search for alternatives to the hospital. This movement is sufficiently vigorous to elicit papers defending an occasional hospitalization.

There are many objections to psychiatric hospitalization. Most significant perhaps is the fact that psychiatry has outgrown them. In past centuries the mental hospital was established, in much the form it continues in today, as an asylum--a shelter from arrest or punishment for those unfortunates who were not responsible for their actions. It was humane, as conceived and popularized in this country by Dorothea Dix, and it was based on the state of psychiatry at that time. Few patients got better; they were not expected to. Confinement was often for life.

Psychiatry has come very far, but the concept of providing asylum--albeit temporary--persists in many of the same hospitals, with the same philosophies. Freud, whatever his influence on treatment of neurotics, did not completely revolutionize the treatment of psychotics; but drugs did. So now people entering most psychiatric hospitals can expect to be home and recovered in a few weeks or months. Still many mental health laws, often hospital rules, and the tempo in many hospitals, seem to ignore the change in the effectiveness of mental treatment. The Mental Health Associations still send their Christmas presents, seeming to believe they go to the same neglected patients year after year. Physicians still refer patients for hospitalization with the recommendation that they stay for good. Judges continue to be annoyed when patients come home before the ninety days or more of commitment are over. Families are baffled to find the relatives they thought they were finally rid of coming home. When psychiatrists write papers entitled "Brief Hospitalization", some mean six months, some overnight. The V. A. still considers a man, if once schizophrenic, always disabled. In some hospitals, a patient has his first intake evaluation after a month's hospitalization. In other hospitals, it is an unusual patient who isn't home and back to work in a month. Psychiatry has developed phenomenally, but its institutions have not consistently kept pace.

Why Should Psychiatric Hospitalization be Avoided?

Obviously many 20th Century psychiatric hospitals are still providing 19th Century asylum. But many psychiatric hospitals have kept pace and provide rapid and efficient treatment. Results in these hospitals offering brief inpatient treatment have been markedly better. Less chronicity, less disability, better rehabilitation, better post discharge functioning, less family disruption, can all result.

Stigmatization

Why keep patients out of these hospitals? Partially because of a set of attitudes and expectations engendered by the asylums. Even if these outdated concepts are not shared by a particular hospital, they may be shared by a patient, his family, his employer, or society. The patient entering any psychiatric hospital takes on a new role in society, a new relationship with his family and friends, and a new concept of himself. The stigma is enormous. No one, however much he may use outpatient mental health facilities, however peculiar, inadequate, or disruptive he may be, is really considered a mental patient until he is defined as such by admission to a mental hospital. An example, from Elaine and John Cummings' book, Closed Ranks, will dramatize this:

> A paranoid woman for some fifteen years had been convinced that she was being influenced by sex rays which came under her bedroom door at night. She suffered also from more transitory delusional beliefs. She had been successfully employed for many years. She lived with a sister to whom she habitually confided her ideas, and this sister had always considered her somewhat eccentric. Her sister had been unexpectedly delayed in returning from a holiday. The patient became anxious and discussed her delusions with a friend. A psychiatrist assessed her, and discharged her after a short stay in the hospital. The sister was reluctant to have her back, declaring that because she had been in a mental hospital she must be mentally ill, and saying, "How do I know what she might do?"

The Cummings also found that, while most people considered behavior which would warrant the most serious psychiatric diagnoses as normal and nothing to be concerned about, these same people would be quite reluctant to have contact with formerly hospitalized psychiatric patients. The stigma is not produced by the symptoms, but by the hospitalization.

Expense

Psychiatric hospitalization is expensive in other ways, too. Operating such facilities is a financial drain on society, in terms of wasted lives and periods of unproductiveness as well as in actual financial outlay for this half of our country's hospital beds. Many patients cannot return to their old jobs and any job may be hard to find. Researchers have documented the enormous deterioration in employment and social functioning following psychiatric hospitalization, and employment rate drop of about 50 percent. There also may be welfare payments for the family of a man hospitalized.

Fred Lewis has forcefully spelled out a series of arguments against psychiatric hospitalization: "The traditional pattern of care for public psychiatric patients in this country is archaic, medically unsound, and uneconomical". "It ignores all the basic principles of good medical care." It does not enable "diagnosis and treatment as early in the course of a patient's illness as possible." "It is much easier to keep patients out of a psychiatric institution than it is to get them out once they have been admitted." "Once the patient is in an institution, the ranks of his community tend to close behind him." "Something also happens to the patient upon hospitalization. The very nature of the institution allows him to withdraw from the stress and strain of life and the patient rapidly learns what it is like to be safe and secure in an environment which offers few challenges but few satisfactions. Once a patient has become accustomed to having his life run for him by other people, it frequently becomes difficult for him to give up the security of the hospital for the uncertainty of life outside of an institution."

Hospitalization: Helpful or Harmful?

If hospitalization really helps, the expense and stigma would be worth it. But does it? Lehrman has shown that the hospital, however ambitious, really accomplishes little more than recompensation, and hospitalization prolonged beyond this point, with or without psychotherapy, is harmful. What is there that helps about the hospitalization, considered apart from whatever treatment is based there? What is helpful about the confinement of the patient in the hospital building and the provision of a bed for him there? Some might say it protects the patient from his family--it separates him from stress. The asylum concept! How much more stressful must it be to enter a strange hospital filled with stranger people than to continue in a familiarly stressful environment

It could also be argued that hospitalization protects the family from the patient. This may be conceivable, but in this era of drugs, few patients need remain violent or disruptive from acute psychosis. Also it must be noted that psychiatric hospitalization is not the only way of separating people who are destructive to one another. If the family situation from which the patient must be separated remains the same, what can be expected to happen when the patient returns home? Querido says "any removal of a mentally disturbed patient from his social background implies a sidestepping of the nucleus of the problem."

Psychiatric hospitalization is an inescapably regressive experience. The scheduling, the routine, the games, the making of ashtrays instead of a living, the separation from normal stress--all these, whether intended or not, are regressive for all patients except those who have already regressed profoundly on the outside.

In addition to the stigma, the expense, the scapegoating by the family, the loss of a job, the alienation and the regression, there is the opening of a greased downhill path to rehospitalization as the familiar and sanctioned way of dealing with crises and problems.

Then Why Hospitalize?

The treatment available in hospitals could be available on the outside. Psychotherapy, crisis or long term, group or individual, drugs, EST, family therapy with the development of a therapeutic milieu in the home, O.T., and volleyball are all available outside hospital walls. Then why hospitalize? There are several reasons for the maintenance of mental hospitals. Mental illness frightens us--all of us, even the professionals. It is often soothing to overreact and hospitalize someone rather than to understand him. Actually, the criteria for hospitalization are unclear. We hospitalize many people because a few may be suicidal or homicidal and we often don't know which. It is well known that increased experience and decreased anxiety on the part of the psychiatrist decreases the percentage of his patients that he hospitalizes. Of course, we already have the buildings and the beds to be filled. At Colorado State Hospital in recent years, new approaches and outpatient services produced a drop in census in one division from 500 patients to 70 in a few years. Staff was laid off, the budget reduced, and there was great pressure to increase admissions and prolong hospitalizations, even if not necessary.

The easiest alternative would be just to close the hospital door. Actually, this has happened in some European areas such as Amsterdam, whose hospitals were bombed out in the war. The result was the discovery by Querido that outpatient alternatives worked quite well. The lost hospitals became unnecessary. Werner Mendel in this country did something similar. He went through a ward and randomly discharged all patients with a diagnosis of schizophrenia. Some had just arrived, others had been there for months. The result was interesting. The readmission rates of those discharged randomly and precipitously were identical with the readmission rates of those hospitalized until more appropriately discharged. But the duration of the subsequent hospitalizations was very much affected. The readmitted patients recompensated in approximately the same period of time as the length of the previous hospitalization, however it had been ended.

Most hospitals have times when the doors are partially closed by the lack of available beds. It has been observed at Colorado Psychiatric Hospital that the percentage of patients deemed in need of admission varies directly with the number of beds available. Pasamanick has shown that home treatment is feasible and does not just postpone hospitalization. His work has dispelled many other proposed objections to the avoidance of hospitalization. It would seem then that closing the hospital door might not be a totally frivolous idea.

Alternatives to Hospitalization

There are sophisticated alternatives to long term psychiatric hospitalization. Partial hospitalization has been found to be useful, but it may be confusing in that no one knows when to use it. Bertram Brown estimated that 75 percent of hospitalized patients could benefit from day hospitalization. It is not always clear which 75 percent should receive day hospitalization, since others feel almost any patient seems to benefit as well from the partial as the 24-hour hospital. In other words, very few patients need full time hospitalization. If eight hours is enough, why not one hour?

What of patients with no families to go home to at night, and those with no one to take responsibility? The use of foster homes and half-way houses has increased for patients who can function with partial independence but require some controls and structure. Nursing homes are useful alternatives for senile and organic cases. But the most dramatic changes in the use of hospitalization are not possible unless we have a theoretical framework different from that of the humane Dorothea Dix and her asylums, and different from the persistent and unsupported idea that longer hospitalization and more in-patient treatment is somehow better. When mental illness is considered the result of bad heredity, or organic deterioration, or failure of ego development, or unresolved infantile attachments, or anything else which marks the patient at birth or in childhood for this almost inescapable later decompensation, any treatment approach must seem futile or at best slow and laborious.

Utilizing the Crisis Concept in Emergency Treatment

With a primary focus on symptoms as a response to crisis, the picture changes. Obviously there is a predisposition to mental illness, and mental health theoreticians struggle long and hard to prove that their own pet idea about a certain predisposition is the only valid one. But the nature of the predisposition is secondary when the patient arrives acutely schizophrenic, or suicidal, or incapacitated by a new symptom. The first questions to be answered in solving his problem must be, "What is he reacting to?" "Why now?" "What is the current crisis?" Invariably we will find there was a time when he functioned well enough and sufficiently symptom free to be tolerated at some level of society without the need for him to knock on the hospital door or have someone deposit him there. What has changed? Certainly not his heredity or his infantile personality. Obviously, he has encountered some stress which he has been unable to handle in a more appropriate way. If this stress is removed he should return to his previous level of adjustment. If he can remove this stress himself, he will not just return to his previous level of adjustment, he will become stronger. Adding an additional stress in the form of a stigmatizing, regressive hospitalization will not assist this process but will impede it.

Crisis therapy has learned much from military psychiatry. In traumatic neuroses of war, the stress is obvious. Much chronocity, disability and regression is avoided by giving the patient a hot meal, a good night's sleep, a chance for catharsis, a pep talk, and a return to the front. This works far better than removal to a distant hospital for more prolonged treatment of the predisposition to breakdown under stress.

Throughout any brief therapy, the non-specific healing factors, described by Jerome Frank, are operative. The patient is given support, encouragement, acceptance a chance for catharsis, and perhaps drugs for symptom and anxiety relief and environmental manipulation. Above all the therapist is available immediately; regression is discouraged and support is given to the remaining healthy, problem-solving capacities of the ego.

Crisis therapy is an effective alternative to hospitalization. The Home Treatment Service kept out 50 percent of those about to be admitted to Boston State Hospital and 70 percent of those referred for Home Treatment. The Community Extension Service in Boston was also successful with from 50 percent to 70 percent. At Colorado Psychiatric Hospital's Emergency Service, admissions dropped from 52 percent to 26 percent of those seeking help when crisis therapy became a third alternative between hospitalization and the usual outpatient referrals. Many other studies have shown similar results.

An extension of crisis therapy is "family-crisis" therapy. This is a logical extension of crisis therapy for two reasons. (1) Most crises are family crises; and (2) when a severely disturbed patient is kept outside the hospital, it is the family that must share the responsibility. It is well known and often documented that the family's attitude is a major determinant in deciding who will be hospitalized, and for how long. The family cannot be ignored in these matters.

I believe it is true that all patients present themselves for hospitalization in a state of crisis. The current symptoms, or decompensation, are usually the result of a recent crisis. Even if the crisis is a recurrent one, as with many marriages, or an unavoidable one, as the period of adolescence, it can still be handled in family crisis therapy, if not in individual crisis therapy. When there are no new symptoms, there may be a crisis within the family which produces a new intolerance of the old symptoms. There may be a crisis with the caretakers who have formerly assisted the family in handling a long-standing problem. There has always been a crisis of some sort, the resolution of which will restore the family and the patient to that level of functioning which was previously tolerated.

An Example of Crisis Intervention Procedures

In our work at the Family Treatment Unit, we have seen a random sampling of the patients with families who were about to be admitted to Colorado Psychiatric Hospital after failing in crisis therapy, or being judged unsuitable for it. The focus has been on the events in the family which led to the development of symptoms or the request for hospitalization of one member. There are seven steps involved in treating these families, and the process requires an average of about five office visits and one home visit over a two or three week period.

Step 1. Immediate aid - The family is seen at once by a psychiatrist, a social worker, a nurse or by all three. This may occur at any hour of the day or night, and the promise is made of immediate availability around the clock from that moment on.

Step 2. Define the crisis as a family problem - A history of all events leading to the crisis is taken from the family as a group. Absent members are called in and significant extended family is included. The interactional aspects of the crisis are stressed.

Step 3. Focus on the current crisis - The past is used only to throw light on the present. Past strengths are stressed.

Step 4. General prescription - Excessive regression is blocked. Reassurance and support are given. Psychotic symptoms and behavior are interpreted as efforts to communicate. Drugs are given for tension and symptom relief to any member of the family who needs them.

Step 5. Specific prescription - Specific tension-relieving advice is given. As the crisis is understood, specific tasks are assigned to the family members for crisis resolution.

Step 6. Negotiation of role conflicts - The conflicts in role assignment and performance which almost invariably preceded the crisis are negotiated with the family members.

Step 7. Management of future crises - Even when long term referral is made, the availability of the family treatment team for subsequent crises is stressed.

With this approach, very few patients have required hospitalization. Less than 10 percent have been hospitalized within the three months following this form of crisis intervention and the vast majority of those who are subsequently hospitalized had been hospitalized previously. At this stage in our follow-up observations, there seems to be no advantage of hospitalization for subsequent level of functioning or symptom relief. Our findings confirm the belief that the greatest number of patients who are hospitalized could have been treated in their homes with available crisis oriented services, a focus on current reality, and an effort to avoid hospitalization.

Brief Hospitalization

Obviously some patients cannot go home immediately. They may not be evaluated rapidly enough, or are unacceptable to their families for return home, have no home to go to, are actively assaultive or suicidal, are realistically uncontrollable, are too sedated from an overdose of medication, or otherwise are unable to leave constant medical supervision. This potentially large group is, in practice, only a small part of the total number accepted for hospitalization, particularly after the crisis and the family problems are understood. We have had much success with this treatment approach by using a form of brief hospitalization in a general hospital emergency room setting. This setting has many advantages for crisis hospitalization. No patient is allowed to stay longer than twenty-four hours. The atmosphere is hurried and intolerant, and the nurses are tough. There is expectation of cooperation and rapid improvement. While the family rests at home, the patient is rapidly medicated and, if necessary, restrained. Outside controls are provided until the patient's internal control can re-emerge as his anxiety or confusion fades with the action of drugs. A few family conferences, perhaps a few individual sessions, and a good night's sleep for the patient are usually sufficient to enable the patient to return to an out-patient setting within the necessary twenty-four hours.

Such a micro-hospitalization would be unthinkable if the theory of treatment for psychosis required a change in the patient's premorbid personality or long-term patterns of functioning. Naturally, treatment for such long-standing problems is readily available on an out-patient basis after crisis intervention is over. It is not at all uncommon for a disturbed patient to enter a general hospital for a rest or for "tests", the results of which are already obvious.

Other Reasons for Hospitalization

During a crisis, hospitalization may be sought for a variety of reasons:

(1) The hospital may be used because treatment is unavailable elsewhere. This deficiency in services can be corrected and has been in many communities. But, unfortunately, insurance programs still encourage in-patient solutions.

(2) The hospital may be used because of prognostic pessimism. This is unwarranted with most cases. Schizophrenia, as we now know, is rarely a progressively deteriorative condition, except when accompanied by the social breakdown syndrome in a hospital. The usual course can be one of exacerbations, followed by long remissions, with the prognosis greatly influenced by the degree of support and acceptance in the family. It has been shown that a family attitude of tolerance of symptoms and intolerance of non-functioning improved the chances of avoiding re-admission.

(3) The hospital may be sought because of its controls over destructive behavior. We have found, however, that drugs, rapid attention to the crisis, and availability to the family reduce the danger of destructive behavior in

psychotic patients to a level at which it is rarely a problem. Overnight emergency room hospitalization is an available safety valve. Visiting nurses temporarily can direct a controlled milieu in the home. Even a live-in housekeeper is a cheaper source of controls than a psychiatric hospital. Of course, many people admitted to hospitals for sociopathic behavior would be more appropriately controlled in jails. There are certain patients, alcoholics, sociopaths, and an occasional hysteric, whose lives seem to be a parade of crises. There is a great tendency to hospitalize these people and attempt to gain control of their behavior. Of course, this rarely works, since the patients seem able to find crises anywhere. The result is either disruption of the hospital or a profound regression on the part of the patient. Hospitals have little to offer such patients, even though outpatient management can be most frustrating.

(4) Hospitals have been used to decrease the danger of suicide. There are many who believe this is unnecessary and perhaps even provocative for the potentially suicidal patient. In Werner Mendel's long list of indications for hospitalization, suicide was specifically excluded. Our work would confirm that suicides still occur in the hospital under the best precautions, and that the immediate post discharge period is a very dangerous one. If suicidal behavior is seen as an effort to communicate and as a reaction to an interpersonal crisis, immediate attention to the message and the crisis should remove the suicidal danger for all but the most chronically discouraged and isolated patients. If suicide is an interpersonal event, the death wishes of the other person toward whom the communication is directed must be assessed, particularly when the suicidal patient is infantile and impulsive. Suicide danger may be an emergency requiring mobilization of many forces, including the family, but hospitalization is rarely a necessary step when the truly appropriate family crisis help is available.

(5) Hospitalization is sometimes sought for covert reasons, in the presence or absence of serious psychiatric illness. If the reasons were uncovered, the hospitalization could be avoided. A patient may want a vacation--a "long rest"--to escape from some responsibility, some decision, or some pressure. On rare occasions, a trip to the mountains or a weekend at a motel might actually be indicated, preferably after the problem is solved. One woman made a suicide attempt in the midst of a marital crisis. The marital problems were worked out during a stormy and exhausting three weeks, at the end of which time her symptoms were gone and she decided to get a brief rest. She called her G.P. and arranged for a brief psychiatric hospitalization so she could rest up after solving her psychiatric problems on an outpatient basis.

(6) Psychiatric hospitalization may be a way of separating people. A man called with the urgent message, "I can't sleep or eat or think. I'm scared I'll lose my job or my mind. You have to hospitalize my wife." We know that only the longest term hospitalization can separate some symbiotic pairs and then only until discharge, but a temporary respite from a chronic battle should never be the reason or the goal for psychiatric hospitalization. Motels, homes of friends or relatives are available. A woman who wanted to escape from her husband sought hospitalization. Her behavior was bizarre but

its intent was clear. An arrangement was made for her to move into the trailer behind her house until conflicts could be cooled down.

(7) Hospitalization may be sought as a means of gaining power over another person. A girl was hospitalized for EST in her parents' efforts to stop her smoking. A large number of the girls brought to the hospital are brought by parents who want to stop their sexual activity. One woman wanted her husband in the hospital so she could gain control of his check book to stop him from spending any of a recent inheritance.

(8) Hospitalizations are arranged to help someone escape from legal difficulties, to help a psychiatrist rest on his vacation, and for a multitude of seemingly practical and often neurotic reasons. In each case, when the covert reason is known, an alternative becomes available. It should be kept in mind that the presence of psychosis is never, in itself, a sufficient indication for hospitalization.

(9) Hospitalizations are prolonged and often instituted because of the therapist's unrealistic optimism and ambitious goals for his patients. Freud felt "it is a worthy undertaking to transform misery into common, everyday unhappiness." Too few of us are satisfied with that goal. We believe in therapy and seem to want to keep people in it forever, even if it requires hospitalization to do it. We often fear that relieving misery will remove the patient's motivation for "real change". Some have advocated a "family psychiatrist" approach in which an immediate problem may be solved, a crisis ameliorated, or a symptom cured with the expectation of a return for a few more visits with subsequent problems. This attitude has served the rest of medicine well, and it fits nicely into a crisis framework for psychiatry.

Summary

With the advent of the consideration of psychosis as a crisis, with an emphasis on the acute, rather than the chronic aspects of the illness, and with the utilization of the many alternatives to psychiatric hospitalization which I have mentioned, the psychiatric hospital may, sometime in the future, become obsolete. The most potent factor promoting hospitalization, when outpatient solutions are available, is the fact of previous psychiatric hospitalization. It becomes a habit, an expensive and destructive habit. With the development of appropriate emergency services, and with the adoption of crisis therapy techniques, we can break the habit.

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Reaction to Dr. Pittman

Theodore Machler, Jr., M.D.

The role of "responder" or "reactor" is to assist in evoking or provoking a wide range of viewpoints. I find myself too much in agreement with Dr. Pittman to offer much in the way of a dissenting or divergent viewpoint. You have heard this type of introduction before, which starts out by saying, "I agree with you, but--", and then proceeds to show the many ways the responder disagrees.

I like Dr. Pittman's ideas because they are optimistic. I like them because they indicate that something can be done. I like his ideas because they indicate and amplify the idea that mental illness is not an irreversible and untreatable "something" that can only be dealt with in isolation or seclusion.

The reversibility of the process of this thing we call "mental illness", in my opinion, is dependent in part upon the avoidance of reinforcement. Hospitalization and prolonged treatment can often be just such a reinforcement. Hospitalization may also provide an alternative to change. Hospitalization often allows patients to become comfortable in their illness. Most of us have heard our patients or clients say, "Changing is much too difficult, much too painful. There is too much anxiety involved. I'd rather just give up and go back to the hospital." Going back to the hospital may be a "giving up" or an avoidance of change. When we go along with this, we are, in legal terms, "aiding and abetting" or we are at least "accessories". By using these terms I am, in part, offering an implication that it is a crime to do these things; perhaps it is. Perhaps it is just the line of least resistance for both patient and therapist. We are implying to the patient, "Yes, change is difficult and requires strength and courage and I agree with you that you don't have this strength and courage. Let's give up." Perhaps if we did say this to our patients, instead of just thinking it or implying it, both we and the patient would reconsider. Possibly we would reconsider out of guilt alone.

The type of response or treatment suggested by Dr. Pittman can work only when there is sufficient manpower, and it is difficult for me to see this manpower available in most communities. I do agree that if a multidisciplinary team were available to spend considerable amounts of time with people applying for hospitalization, then hospitalization could be avoided in most cases. Ay, but there's the rub. This manpower is not available, at least universally. Then hospitalization becomes the compromise--just as medication can often become the compromise. However, no matter what the manpower problems, continued attention can and should be given to reducing the incidence and duration of hospitalization when adequate alternatives can be found.

Dr. Pittman has indicated that there is considerable stigma related to psychiatric hospitalization. I feel that perhaps a point is being missed here in blaming it on the hospitalization. More often the stigma is related to an intangible something called a diagnosis, which may or may not mean something. For example, there is a lot less stigma involved in having "a nervous breakdown" or "a little depression" than in having a schizophrenic reaction (whatever that is). I would predict that the statistics on re-employment of hospitalized patients would bear this out--that re-employment is largely dependent on the diagnosis. Some states (and I regret to say Florida is one of them) require either through statute or practice that a patient be designated psychotic before they can be admitted to the state hospital, and, as we all know, this results in many people who are not psychotic being designated as such in order to get them hospitalized, with the result that these people are "branded" with this diagnosis. This, of course, affects their civil rights, their insurability, and their re-employability. Undoubtedly some of the stigma is a reflection of the community's fear and anxiety regarding mental illness and emotional problems, which in turn may result in some excesses in hospitalization. Fear often leads a community to become aggressive toward the patient and to remove him as the cause of anxiety.

Although still in essential agreement with Dr. Pittman's paper, I am apprehensive regarding the tendency to "over-respond" to a good idea. Terms like "brief hospitalization, crisis therapy, turnover, hospital-avoidance, partial hospitalization, brief therapy, alternatives to hospitalization," etc., can become semantic traps. They can become the master and we become "fixated" on them to the exclusion of rational or adequate treatment. We might tend to rest smugly behind such terms (which could acquire the semantic equivalent of the "American Flag", "apple pie", and "community-oriented"), and in the safety of these high-sounding phrases we could easily become enmeshed in an abundance of abuses.

For example, the terms "brief hospitalization" and "turnover rate" are frequently used as a measure of the efficacy of treatment. I have heard hospital administrators, superintendents, and others proudly comparing their "turnover rates" and their "length of stay" statistics. This is a reflection of what I call the "turnover or rotisserie syndrome". Unfortunately, there is a large percentage of the same persons getting turned over, with additional basting each time. I often hear clinicians proudly discussing the short length of stay statistics on their patients. What they often fail to add is that this is the eighth or ninth or fifteenth short stay for this same patient. Very often this type of statistic becomes a way of rationalizing or justifying inadequate treatment.

One reason for the "rotisserie syndrome" is an allied ailment known as the "I don't want him, you can have him, he's too sick for me" syndrome. This starts with the family contacting the doctor or the community agency and saying, "I don't want him. You can have him, he's too sick for us." The doctor or agency then calls the local hospital and says, "I don't want him. You can have him, he's too sick for me." After a few days or weeks in the psychiatric unit of the general hospital, the county judge and the state hospital are contacted and told, "We don't want him. You can have him, he's too sick for us." Thus the state hospital then accepts this patient and being subjected to the continual pressure of this syndrome, reacts with the other syndrome called "turnover". These syndromes can be repeated reciprocally several times, and can be accelerated with indigency and certain diagnoses. The end result is that the patient is then returned to the community, often in a condition very similar to that in which he left.

Crisis therapy, as pointed out by Dr. Pittman, may not be applicable to all patients. I have seen occasions when a person dedicated to the idea of crisis therapy would try to apply it universally. Those persons with problems of long duration, those without readily ascertainable precipitating factors, and those who over a period of years have come to expect hospitalization as their only way of achieving "wellness" respond more rapidly to hospitalization. For many people, existence has become the crisis, and adequate intervention for them is rarely brief.

Partial hospitalization conventionally means "part time" hospitalization. It may also mean inadequate hospitalization. Hospitalization is a term that is often misused. Is it really "hospitalization" to admit someone to an institution with inadequate staffing, where only selected or "good prognosis" patients (usually female, young, and attractive) are selected for active treatment, while others receive milieu and supportive treatment. Many hospitals brag of their active "milieu programs". This in reality is often an institutional rationalization for inadequate staffing and/or inadequate treatment. For such an institution, milieu therapy might be defined as making a hospital seem less like a hospital. This would seem to be the hospital's admission that there is something undesirable about hospitals in the treatment of mental illness. Dr. Pittman has mentioned the utilization of foster homes and half-way houses. These, too, can become institutions, or an extension of an institution. The term half-way house implies a distance that is equally close to the hospital as to the community.

I hope that the emphasis will not be overdetermined, but realistically viewed. I hope that adequate alternatives to hospitalization will be utilized wherever possible. To do this job adequately requires manpower, community acceptance, and a realization that alternatives to hospitalization will be resisted by professionals, patients, patients' families, ad by all who are accustomed to hospitalization as a solution to most mental health problems.

In summary, I would say that there can be good hospitalization and bad hospitalization, and it is quite possible to have "good" hospitalization as well as "bad" hospitalization. It is equally possible to have "good and bad" non-hospitalization. Dr. Pittman has clearly indicated an alternative to hospitalization, and has shown that adequate treatment and intervention can be this alternative.

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MANPOWER: UTILIZATION OF NON-PROFESSIONAL CRISIS WORKERS

Samuel M. Heilig

Let me extemporize a bit to some of the things I have heard today, and as I have observed the scene regarding emergency service and crisis intervention or suicide prevention services. In trying to conceptualize what is meant when these terms are used, I tend to find myself at a loss. One of the things I hear, as mentioned by Dr. McPheeters earlier, is that emergencies or crises represent a special state of disorder for mental health professionals to deal with. I am not entirely sure that is realistic. I think there are especially acute stages of disorder, but I wonder if emergency services as they are organized will be seeing people who represent a qualitatively different disorder than those now seen in existing mental health facilities.

What I think is often included in the notion of emergency service is time limited treatment, or "brief therapy". Crisis therapy is often synonymous with brief therapy, or short-term treatment. One of the most important elements included in a crisis intervention service is that it must be readily available when people need it. If it is to come about that mental health services are to be available around the clock, when people need them, I think you soon come to the problem of how will these services be provided and where will the manpower come from. Dr. Ray described the situation in Florida, and clearly pointed out the shortage of trained people in this State. With the currently developing comprehensive community mental health centers, one wonders where staff will come from. There certainly are not enough people now even for the existing facilities.

Background of the Suicide Prevention Center Volunteer Program

At the Los Angeles Suicide Prevention Center, we were pressured by demands for services from the community, and three years ago, we began using volunteers to meet our manpower needs. Volunteers proved to be very helpful in our program, and may be a valuable resource for delivering mental health services. Our Suicide Prevention Center is a small staff of ten professional people. We have been organized since 1958, and during the course of that time we have had increasing pressures from the community due to ever increasing demands for service. We have had almost a geometric progression in the number of new calls to the Center. The ten people on the staff were simply unable to keep up with these demands from the community. We had to make a variety of changes to try to provide the service being requested of us. One of the programs we instituted is utilization of non-professional volunteers.

The Night Watch

A program I will not spend much time talking about here is the one we call our Night Watch, but let me just briefly touch on it since it is also of interest. The Night Watch consists of a group of people who are in training for the mental health professions, and related professions like the ministry and medicine. They are usually students in graduate schools and have considerable training and some beginning experience in mental health work.

This program pre-dated the volunteer program. We utilize forty of these people to do telephone interviewing outside of regular office hours, and they receive some payment for working.

Beginning the Volunteer Program

We decided to use volunteers because we needed help, not for the sake of using volunteers. This may sound polemic and probably is, on my part, but I have noted that there are some agencies or people who think it is just "the thing to do". They decide to have some volunteers, and then they go about seeking a task for the volunteers to do. The relevance of this is that if you really need help you will know what help you need, and you will be able to orient any program using the volunteers around the specific tasks with which you need help. I will get back to this point later on.

The idea of using volunteers had been discussed among the staff for maybe a year. It was known that at some point we would need additional help, and we had thought we might try to use volunteers. When it was finally decided that now was the time to do it, we proceeded quickly. We let it be known among the professional community and colleagues that we were going to begin selecting workers, and asked them to refer people they knew who might be suitable candidates. We described the task which we had in mind for them. Of the 16 applicants, the majority came from the Director of the Mental Health Association in Los Angeles County, who frequently had calls from people wanting to do some volunteer work in mental health.

Selection of Volunteers

I might say as a backdrop to this that during the history of the center we had dozens of calls from people in the area who volunteered to work in suicide prevention. They initiated this contact, and they tended to be people who had their own solutions to all of life's problems, including suicide. They were interested in graphology, numerology, metaphysics, astrology, etc., and wanted to use suicide prevention to promote their own ideas. None of these were included in the group of 16 applicants who were referred by someone who knew them, and also knew the work of our Center.

The actual selection procedure was a fairly elaborate one in that all the applicants had to be interviewed by at least three members of the staff. All three had to agree on the suitability of each person. If there was one who thought the person unsuitable, she was not accepted. In addition, they were given an MMPI, simply to eliminate any gross personality disorder or defect which might not be picked up at the interview, and also for research purposes. Nobody was eliminated because of the results of the MMPI. They were also asked to write a 1500 word autobiography. I am not entirely clear why we asked them to do that, but probably because Margaret Rioch had done it in the selection of her people for the program in Washington. I might add that asking anyone to write a 1500 word autobiography is an excellent test of motivation.

Selection Criteria

I want to talk briefly about the criteria we used in selecting people for the program. I should preface my comments by saying that we did not have any criteria when we started; they developed as we proceeded. It was really after we looked back at what had happened that we developed and organized this set of five criteria for our volunteers.

(1) - Stability. When you interview an applicant and ask him about the general course of his life, you may find that there are no major disruptions in it. The volunteers don't usually have atypical lives. It is easier to describe this negatively: they don't have, for example, numerous marriages, or a history of hospitalizations for mental illness, or they are not highly transient in their residence and jobs. They don't present any gross disorders as they tell you about their lives. This absence of disruption and discontinuity in life is what we mean by stability. The interview usually included some questions about personal crisis. Most people during the course of living have some crises to contend with. We were not so much interested in the nature of the crisis as we were in the way they dealt with it. What response did they make to the crisis? Did they act impulsively? Did they break down over it? Or did they, in some way, mobilize their own resources to deal with it in a constructive way? This is a very important thing to know. You can learn these things from the way people tell you about particular events in their lives. Some people become diffuse and disorganized in trying to recount certain incidents, and they get lost in it. I usually surmise that they really did not contend with it adequately at the time it occurred, but rather they avoided it in one way or another. We thought people who evade crises would not be suitable to work in a task where they would need to deal with fairly serious crises.

(2) - Motivation. The next thing we looked for was motivation. Most of the people who applied for this program said that they wanted to do something useful. Their children were now grown and they were not needed so much at home as they had formerly been. They had time on their hands and wanted to do something constructive. Several of them had tried other activities or service which had been unrewarding or did not challenge their capabilities. This was the most frequent and usual motivation on the part of the women. What we wanted to know in terms of motivation was whether they would sacrifice the time and energy to work hard. This was partly tested during the application procedure. They had to come back to the Center for these interviews and tests at least two, maybe three times. They were clearly apprised of the time that would be required both for the training and also for the work requirement we would make of them. This was a fairly heavy investment of time, and they agreed they would do it.

(3) - Sensitivity. Another aspect we looked for which is difficult to measure was sensitivity. The word has many meanings to many different people. My own way of trying to estimate someone's capacity to be sensitive is to look at his ability to recognize different kinds and levels of feelings, and his capacity to respond to them in other people. One way I tried to gauge sensitivity was to ask the

volunteers about situations which they had experienced in their lives, and try to get some feeling for how they responded. If you do this with enough people you will find some have a rather rigid and uniform way of responding to all kinds of external feeling experiences with other people. They tend to always do the same thing, particularly if the feelings they are confronting make them anxious. There are some people who are always sweet, for example, and very helpful. But this is not always the best response. Other people are capable of various kinds of responses: they can be authoritative, they can be firm, they can be gentle, they can be sad. They respond with a broad range of feelings, depending on what is confronting them.

(4) - Willingness to Learn. Another thing we looked for was the ability to accept a learning position. This criterion became clear in thinking about some people whom we did not accept. There were two applicants who came in and told us how to run such a program; indeed, they offered to direct it. They had all kinds of ideas, and some of them were good ones. But we felt that they would be disruptive in the program. We didn't want people who thought they knew more about suicide than we did. We wanted people who would be able to learn our procedures by participating in a training program.

(5) - Group Centeredness. The fifth criterion was ability of the individual to work in a group. This characteristic was easily discernible during the training aspect of the program. We did not want people who were hypercritical or complaining, or people who tended to isolate themselves and would find difficulty in getting along with other people. At our Center we work very closely and collaborate a great deal in our work; we consult frequently about cases and we wanted people who could participate in such a climate. For simple, practical reasons we did not want people who might be disruptive to the group.

Experience Gained From the Volunteer Program

Trainees Selected

We selected ten out of the 16 applicants, and let me briefly describe them. They were all women in their late 30's or early 40's; all were married and had children who were either grown or in school, so that they were free from immediate responsibility for the children; they were all in the middle or upper classes economically; they were mostly housewives, although a few had some temporary, recent work experience. There was a good bit of variation in the spouses' occupations: two were skilled craftsmen; three ran or owned successful businesses; two were physicians; one was a psychiatrist; the remaining three were a lawyer, a banker and an engineer. Although they were not selected for this, all of the women selected had some college training, and some were graduates. Another interesting finding about the group was that six of the ten had enjoyed a successful experience in psychotherapy. One was still in therapy, and it was with her therapist's consent that she participated in the program.

We asked them about suicide, specifically if they had had any experience with suicide. None had, in any immediate way. Nor did they have any particular attitudes or any set opinions about suicide. They had the usual kind of mixed feeling about it, but they had not spent much time thinking about it. I might mention that during the selection procedure these women were unusually revealing about themselves, and even more revealing in their autobiographies. I am not sure how to understand that, but one thing that I think these women wanted was acceptance by us.

Training for the Volunteers

Let me go on to describe how we organized the training and what was included in it. My own attitude about the training was that the volunteers were always in training; that they were coming to learn, and in addition to learning something, they would be providing some service. This was the beginning orientation for these women. A program was set up for five weeks of more or less formal training, followed by an apprenticeship, which was continuous. The initial training was for a five week period of two full days each week. This included presentations and discussions in which all of the staff participated.

The content included three major areas: theoretical presentations, methods or techniques, and clinical or case presentations. Some information about personality was included in the theoretical area. You must understand that these were women with no prior experience or training in mental health work, and we thought they should have some information about how mental health workers understand people and personality. So, we gave them a general overview of psychological thinking. They also had some theoretical presentations aimed at helping them understand suicide, and the meaning of suicidal behavior as we conceptualize it. This included concepts such as communication, the cry for help, ambivalence, significant other, reactions to death and dying, crisis, helplessness and regression.

Training for specific methods or techniques included such things as how to conduct a telephone interview; how to evaluate potential suicidal danger, or lethality; available resources in the community; how to mobilize resources around a particular crisis; and how to identify and focus on the precipitating stresses so that the worker and the patient can arrive at a definition of the problem and thus move toward appropriate actions.

To provide the clinical material, we used a series of taped telephone interviews which proved very useful in training people to conduct telephone interviews in crisis situations. These were very helpful and were used extensively to give the trainees an idea of what an interview sounds like, and to let them hear a skilled person conduct such an interview. There were also case discussions where the staff would present current cases. As a staff member took a call, he would discuss it with the trainees, and this enabled them to observe the usual working procedures of the Center. During the latter part of this five week period, some of the volunteers began to take calls which were then brought back to the total group for discussion.

Following the five week period, all the members of the group began an apprenticeship. To accomplish this, a roster was established with two volunteers scheduled each day, and a staff member scheduled as their supervisor and teacher. This served a dual purpose of additionally helping new volunteers learn the task they were setting out to do, and it also gave us a check on their performance.

Response of Professional Staff to the Volunteers

We had some questions about whether there might be some staff resistance to the utilization of volunteers. During the early part of the training program, there were indeed some resistances by two members of the staff. There was a heavy demand on them to participate in training, and they wondered if it would be worthwhile. There was enough work to do without taking on this additional burden of training. The volunteers also participated in this. During the third or fourth week some said, "You know, you people are devoting an awful lot of time to training us, and will the Center get anything out of it?" There was probably even some resistance on my part, that showed itself near the end of the training program, when it was time to think about the volunteers taking calls. I became apprehensive and extended the training, as I did not think they could do the job. Probably this was my own anxiety or resistance. In the fifth week, they said, "Well, when are we going to start answering the telephone?"

For the most part, once the program got under way and they began taking calls, there was great exchange of good feeling between staff and volunteers. There was a kind of elan in the group; the staff became quite interested in observing the volunteers work, and indeed encouraged them to do more than simply answer the telephone. They invited those who were interested to sit in on interviews, when patients came into the Center. This permitted them to have an even broader picture and understanding of people in a suicidal crisis. Also, we had a regular meeting one afternoon each week. The total group of volunteers continued to meet, as part of on-going training, and used the time to share their own ideas and development with each other and with the staff. This served a combination of purposes: it was partly a clinical meeting where cases were discussed; it was for training in particular areas in which they felt they would like more knowledge. They have asked for help in understanding personality and personality disorder; psychiatric interviewing; how to conduct an interview; and the process of therapy. We have provided sequences of training around these subjects. They have asked for reading lists, and these are discussed in the weekly meeting. In general, as the volunteers became more enthusiastic and involved in their work, the staff, likewise, became increasingly enthusiastic in its appreciation of the volunteers.

Evaluation of the Volunteer Program

In evaluating this program a year later, we did one thing which might be of interest--we gave all the volunteers a questionnaire. Whereas ten volunteers began, only seven remained a year later. Three had dropped out for the following reasons: one we dismissed, a second had to drop out early because of unanticipated problems in her family (she had small children, and really should never have entered the program); and a third was away because of illness. The seven who responded to the questionnaire felt the major benefit of the program to them personally was a feeling of doing something worthwhile; they enjoyed the work and thought it was useful; they thought they had experienced some personal growth from doing the work; they also enjoyed associating with the staff and being a part of the setting. There was also much comment about the value of learning in new areas.

Problems of Using Volunteers

Let me talk now about some of the pros and cons of using volunteers, and some of the problems which may arise.

(1) - Separation From the Program. The problem came up of having to dismiss a volunteer because she was unsuitable. She was entirely too anxious about every call, she was not able to get the information which was required during a telephone interview in order to make a judgment about suicide potential and the precipitating stress. The problem came up of how to fire a volunteer, which was a difficult task. I don't have any answer to this. Subsequently, when people applied to participate in the program, we made it probationary at the outset, and invited them to drop out if they thought the program was not suited to them. If we felt they were not suited, we would talk with them about dropping out. We have held discussions among staff on the question of whether to use such a person in some other capacity, but we have decided not to cater to the needs of the volunteer but to do what was best for the Center.

(2) - Increased Size of the Center. When you use non-professional volunteers you actually use them in large numbers because they don't work every day, and the added size becomes a burden to contend with. The simple fact of size creates problems. For example, the staff tended to be a rather intimate group, which knew each other's cases, and what everyone was doing. When we suddenly doubled the number of people we were involved with, there were too many to keep up with easily. I think there is a cut-off number, probably around 15, where a group becomes large instead of small. Beyond that point, you soon have a different atmosphere of work. In addition, the irregularity of the volunteers' work presents problems in keeping abreast of who is responsible for a case. When a caller calls back a day or two after the initial call, how does the next worker effect a smooth and consistent transition?

These are problems which can be solved, but they called for a readjustment of the program we had had earlier. They are really not problems of volunteers per se, but rather of size. But of course, the addition of volunteers precipituously increases the size of any organization.

(3) - Boredom From Inactivity. A special problem for the volunteers occurred when they had no calls, or only a small number of calls. When people volunteer to do some work, they need work to do. When there was not enough work it was a demoralizing day, and they would complain. They never complained about being overworked, but only when they did not have enough to do.

Evaluating the Volunteer

Let me end with some comments about trying to evaluate the usefulness or the capability of non-professional volunteers. I am not sure how you can evaluate the effectiveness of a program in any mental health endeavor. The way I think it is usually done is simply to count numbers. Do people indeed utilize the service? In our case, did these volunteers take many calls? After one year our volunteers took one-third of the calls, and it was our feeling that this made it a successful program. We have had two subsequent groups of volunteers whom we have trained, and the volunteers currently take all the new calls to the Center. Hence, in those terms, this is a highly successful program because the volunteers are effectively meeting our need to provide a telephone service to the community.

The way we measure effectiveness in terms of their clinical performance is, I think, the way it is usually measured by clinicians and their colleagues. I think all of us are evaluated by our colleagues. We know some of us are pretty good, or we think they are; and we know others are not very good. I think we judge the effectiveness or capability of our volunteers simply on the basis of their performance, as they consult with us, and as we observe their work. We know who has more capability, who has special qualities to do certain kinds of tasks, and who has ability and interest in particular kinds of cases.

Summary

However, what to us is most important, is that we now know our experiment worked. We know we can select and train non-professional volunteers to do a major portion of the crisis work of our Center; we have demonstrated this fact to our complete satisfaction. We are committed to the utilization of volunteers. We shall continue to use and investigate this method of delivering crisis service, and we most heartily commend it to your attention and consideration when you contemplate establishing an Emergency Mental Health Service.

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Reaction to Mr. Heilig

Darrel J. Mase

The concept of other people doing the work which we have been taught that we alone can do is indeed frightening and threatening. The guild system in the various health and education professions has furthered the concept that what we are taught, we alone can do. It now becomes necessary to consider mindpower in meeting manpower needs by delegating responsibilities and at the same time maintaining supervision. Through this procedure, quality can be maintained while quantity is increased. It is indeed frightening when we discover that somebody else can do many things as well as we can.

As a dean, I think you might better understand my biases if you have my job description. It is written by that most prolific author, Anonymous.

I'm not allowed to run the train
Or see how fast 'twill go,
I'm not allowed to let off steam
Or make the whistle blow,
I cannot exercise control
Or even ring the bell,
But let the damn thing jump the track
And see who catches hell!

I have a feeling that's probably a description of your job too, especially if you are training people to do work you once felt only you could do.

I was glad to hear Mr. Heilig get away from the use of the work "non-professional". How many non-professionals are there in this room? So often we hear those in the health occupations referred to as "sub-professionals" and "non-professionals". A much better term is supportive personnel. The janitor is one of the most important people in the public schools. He does more to develop character in youngsters than does the teacher with forty children because he is with them on the playgrounds, in the locker rooms, and he is there year after year. The janitor is not a non-professional whether in the school or in the hospital. Margaret Mead insists that we give dignity to any job, no matter who does it.

The word "paramedical" also deserves our attention. Words are important. A group of physicians met in Virginia a few years ago and decided to use the word. Their decision is difficult to understand especially when a professional, who is around so many prefixes and suffixes, does not know or seem to know the derivation of the prefix "para". Doland's Medical Dictionary says it means: "beside, beyond, accessory to, apart from, against." Two of the five are all right. Webster's says: "by the side of, besides, alongside or by," but it also says "past, beyond, to one side, aside from, amiss." Why use the term "paramedical" which is open to misconceptions when we can use phrases such as health related, allied, and associated health professions?

Manpower utilization in health and education has received my attention for several years. Time does not permit me to tell you of our experiments with psychological assistants. But Ph.D.'s in clinical psychology are discovering that there is little left for them to do which psychological assistants can't do under their direction and supervision. We are discovering that most professional people now become managers of services as they see others working under their supervision and direction. We used to have CCC camps to keep people off the labor markets, now we use colleges and universities. Seventy-five percent of all high school graduates will have an associate degree by 1975. As an old-fashioned, poor boy from Kansas, I believe it desirable to teach this seventy-five percent how to earn a living while remaining in school longer. It is essential that we make more efficient use of mindpower.

A Ph.D. was necessary in order for me to become a speech pathologist. It was necessary for me to get a Ph.D. to learn how to whistle so that I could teach the child who lisps to say "Sunday School". But psychiatrists, social workers, psychologists, whoever you are, can also whistle. Or volunteers can whistle! Or speech therapy assistants prepared at the junior college level can whistle! By my supervising others, my staffs of whistlers can be multiplied. Quality can be maintained as we increase quantity of services, so long as supervision and direction is present. Our society has charged us with providing good health and well-being for all. Before we even get medicare and medicaid into business, we are now talking about preventicare.

The questions on manpower to be considered in your workshop discussions are indeed interesting. Which professional disciplines will find it most difficult to accept the supportive personnel? It is yours, whatever profession it is, that is going to have the most difficulty in accepting supportive personnel. Consider also the mindpower concept in your deliberations. After all those years and years of going to school, including internships and residencies we acquired some knowledge in our heads and learned to do some things with our hands, and we were also taught that nobody but us could do it. Now, physical therapists will no longer be the only ones to "lay hands on". Physical therapy assistants and aides will do much of this under the supervision and direction of the physical therapist. This adjustment will not be easy, because of the "resistentialism" of professional groups. We have more featherbedding in our health and education service programs than we have on the railroad with engineers in diesel engines. We must decide what jobs have to be done and then prepare people at various levels of preparation to do them, and then we must maintain the supervision to see that the jobs are well done. All these changes are going to be threatening.

The most constant factor in society is change. Let me repeat the lines of Professor Niebuhr as you face the inevitable--change. "God grant me the serenity to accept what I cannot change, courage to change what I can, and wisdom to know the difference."

God bless you, as you give up some of the things that you were taught only you alone could do.

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A COMMUNITY APPROACH TO CRISIS INTERVENTION

Richard K. McGee

The story I want to tell in this paper actually had its beginning in Chattanooga back in December of 1964. A group of about 20 interested, concerned local citizens had been called together by the Metropolitan Council for Community Services; their mission was to plan for the establishment of a suicide prevention center. The scene was one of those "smoke filled rooms" in a downtown hotel where so many of the deliberations which affect our daily lives take place. The consultant was Dr. Harold Hildreth, there to represent the growing interest within the NIMH for such activities. It was now 33 months ago, and there were almost no guidelines, no directions in existence for the job which had to be done. There were only 11 suicide prevention programs in the country at that time; most of them had no visibility to the general public. Louis Dublin's _Sociological and Statistical Study_ of suicide was off the press only a year, and the Farberow and Shneidman _Cry for Help_ was yet to appear in its popular paperback edition. These books listed the suicide centers in existence in this country during that era, and neither of them cited more than four programs in any detail.

But Dr. Hildreth's knowledge of suicide prevention services was vast and broad; he had been one of the guiding lights in the founding of the Los Angeles center, and he was already at work conceptualizing for NIMH an embryonic idea which was eventually to become the Center for Studies of Suicide Prevention. He described the character of the Los Angeles program, and he quickly convinced the group that it was not a model which any local community could hope to adopt; it was not practical to think in such terms. Hildreth cited a few examples of other programs around the country. One of them, he said, was a perfect example of everything that a good program should _not_ be. This was the dilemma which the Chattanooga group found itself confronting.

Origins of the Community Model

It was this experience that made us realize that some new idea, or some new concept was needed for the development of crisis services. Therefore, over the past three years, I have been pondering, experimenting with, and sometimes actively promoting a "community" approach to suicide and crisis intervention programs. This approach does not prescribe a set of organizational patterns, nor a recipe for step-wise developmental procedures. It is really a set of concepts--a system of beliefs. These beliefs are based directly upon some of the principles which we have seen developing in the arenas of community mental health programming since the publication of the Joint Commission Report.

The Community Approach

The principles which form the skeleton of this model have been discussed many times in other places, and I intend to only briefly mention them, and then move on to some data which we have recently gathered on the various crisis programs currently operating in the United States.

The basic concepts are simple enough; the key words are volunteers, consultants, prevention, competency, integration, and evaluation. They go together to form a modern community health program in the following way.

(1) - Volunteers. Because of the increasing demand for a wide variety of services, and the increasing shortage of professionally trained manpower, the utilization of specially selected and trained supportive personnel--lay volunteers--has emerged as an appropriate solution.

(2) - Consultants. Because the volunteers must have access to professional consultation, and because of the inefficiency of individual treatment methods, more and more professionals are assuming the role of the consultant rather than the role of the primary therapeutic agent.

(3) - Prevention. There is an awakening to the potential power of the Public Health model, and community systems are beginning to adopt the goals of primary and tertiary prevention in addition to the standard medical model which stresses only treatment.

(4) - Competency. There is a growing aversion to the concepts of sickness and disease, with a new focus on the notion of social and functional competence, and a concern with normal stresses arising out of the problems of living.

(5) - Integration. No agency or treatment service can stand alone, but each must align itself in an integrated fashion with all of the care-giving resources to form a community network of helping agencies and individuals.

(6) - Evaluation. There is a growing interest in a research enterprise directed at evaluating how effectively a program is actually performing its mission, even though the process may be threatening and the results disquieting.

Any program, however organized or administered, which includes these concepts in its operation is, by definition, a "community approach" to its target problem. Otherwise, an agency is only masquerading under the banner--a parasite on the avant-garde--of the community mental health movement. It may be located in a community; it may be supported by community funds; it may serve all members of a community through sliding fee scales with even "no charge" categories; it might have been established by citizen action. But if it adheres to a 1940 philosophy of clinical practice, it is but a proliferation of the out-moded establishment.

I recall recently interviewing a young psychologist who presented himself as "deeply interested in Community Psychology," and he thought he would like to have a staff position we wanted to fill. He had spent all of his time in hospitals; his internship, and even his post-doctoral training had been at prominent in-patient settings. Now he wanted to get out into the community--he was seeking a place where he could spend the day extending his psychotherapeutic arm of support to out-patients in a community clinic or counseling center. I wonder how many men are being poured out of psychiatric residency who consider themselves "community psychiatrists" because they see patients twelve hours a day in their private office in some medical shopping center, rather than in a state hospital. I think this is sufficient for you to at least understand what I mean by the adjective "community" in relation to a mental health service.

Motives for Establishing an Emergency Service

We have observed in several communities where we have been called upon for consultation that there are different motives behind the establishment of a suicide prevention service. I believe it helps to understand different programs if we try to think of why the service initially came into being.

(1) - Providing Service. One of these motives--one extreme of the scale--is that of providing a service which will answer the cry for help from an individual case. Usually it is out of compassion over the suicide of some single individual whom we know about, who is close to us, and who symbolizes a mass of other individuals in the community, that a program is spawned. We read only this morning in the *Tampa Tribune* about a clergyman in Knoxville, Tennessee, who was found yesterday by his secretary in the church basement; he was dead, apparently from suicide. Now there is going to be a suicide prevention program in Knoxville anyway; it is already being planned, and there is a representative here at this conference. But that event surely will help crystallize and create the program, and probably would have started some action if it had not already been started. The primary motive in this endeavor is to create and deliver a service; the decision points in the organization are made around the questions of *who* should deliver the service, *where*, *when* and *how* the service should be delivered.

(2) - Community Health Problem. Then at the other extreme, there is the motive of overcoming one of the major community health problems. The effort here is to mobilize the network of agencies within the community to mount an attack upon some problem, just as communities have been mobilized to launch campaigns against tuberculosis, infant mortality, malnutrition, and a host of other public health concerns. We can see this motive apparent in several existing programs, particularly the Emergency Mental Health Service in Atlanta. The primary motive here is not just to treat the afflicted, but to prevent the incidence of the afflication. Decisions that are made in the program planning are made on the basis of the prevalence and the ecology, the demography and the etiology of the problem.

(3) - Comprehensive Community Mental Health Center. Now it seems to me that a third motive is emerging for the development of crisis intervention and emergency services. This is the

motive of claiming one of the five essential elements which must be satisfied for the allocation of Comprehensive Community Mental Health Center funds. Every comprehensive center must have an emergency service. Every would-be applicant, agency or community must include some kind of reasonable facsimile in order to qualify for a piece of this federal pie. The primary motive here is to satisfy the terms of a financial contract between the states and the federal government. In planning programs from this base, groups run against a whole host of administrative and budget problems, grantsmanship, and all of the bureaucratic entanglements of the merit system, job classification, etc., which other planning bodies are able to escape. Staffing, of course, is only one of the paramount concerns.

It should be obvious that the output of any agency is based in part upon that combination of factors which precede and influence its development. For example, the assumptions which are held by the people in a position of control, plus the motives that drive those who instigate the service, almost predetermine that the service will develop in certain directions. If the motive is to solve a public health problem, and if it stems from belief in certain community mental health programming principles, a particular type of service will result. Such an agency will automatically look for support from volunteer, supportive personnel; it will reserve, but definitely utilize the professional as a consultant; it will seek to prevent a condition from developing with as much energy as it treats the cases already stricken; it is going to be alert to the normal stress reactions of people experiencing normal crises in the life cycle; and it will try to find out how well it is doing. These things will be built in, because of the underlying attitudes and the motive for the program.

The Prevalence of the Community Approach in Existing Crisis Services

For several months now, I have been delighting in the fact that at least one of the suicide prevention centers here in Florida is (thus far) a living demonstration of both the validity and the viability of the community approach as I have been conceptualizing it. Lately, however, I have begun to recognize that one program cannot, by itself, be very convincing evidence of anything. So, to find out just how universal these ideas might be, and as a prelude to a multi-center evaluation project now getting under way, we attempted to survey the suicide prevention services across the country.

Centers Included in the Sample

Questionnaires were mailed out in February and March of 1967. At that time there were 40 agencies which could be identified and located. The roster of services was taken from the listing in VITA, which is the Newsletter of the International Association of Suicide Prevention, and from our own mailing list which has evolved out of various types of correspondence.

Letters were sent to all 40 of the programs, located in seventeen states and the District of Columbia. Usable replies were returned from 36, or 90 percent of these groups. The four which did not reply were all in

California. It is very difficult to survey every agency involved in this work; new ones are appearing at such a rapid rate. The recent list in the first issue of the Bulletin of Suicidology brings the current total to around 50 centers. Just since this Conference began we have learned about the new service Dr. Peachy is developing in the Public Health Department in Philadelphia. In any event, the data we were able to collect represent over 70 percent of the existing services, and cover the entire geographical distribution. It is safe to conclude, therefore, that the data adequately reflect the current "state of the art" in the development of suicide prevention and crisis intervention services.

Results of the Survey

Each of the centers was asked for data which would describe the agency structure, the type of manpower it utilized, and the clinical services which it rendered. The following are a few of the things we learned about the existing programs.

(1) - Time Since Establishment. The great majority of these programs are very new. Their life span to date ranges from 8 months (one program was established in January, 1967) to over 61 years. The great skewing here is accounted for by the National Save-A-Life-League in New York, which opened in April, 1906. But 89 percent of the programs have been started since January 1962; 67 percent were opened in 1965 and 1966.

(2) - Initial Leadership. There are two primary sources of leadership in getting these agencies started: One of them is the local chapter of the mental health association, which accounts for 39 percent of the programs. Another 33 percent were started by spirited, energetic, enthusiastic, dedicated local citizens who saw a need and responded to it.

In a large number of cases these two forces--individual citizens and mental health associations--worked together. But 72 percent of the existing programs were initiated by lay, voluntary organization leadership.

Less than 30 percent had any direct professional involvement; only 25 percent were organized by the staff of mental health clinics or hospitals.

(3) - Financial Support. The financing of these programs has been largely by private contributions. There are some programs which exist for $300 or less per year.

Only 5 percent of the agencies receive any share of United Fund or Community Chest money; only 8 percent charged patient fees.

On the other hand, 89 percent of the centers receive their support from mental health associations and local civic clubs or foundations or other private voluntary contribution sources.

Only 22 percent of all these programs receive any support from city, county, or state government, and only 8 percent tap funds available from the federal government.

(4) - Office Facilities. If a service is going to be a part of a network of agencies, it must have the image of an agency and that means it must have a physical place to work. Two-thirds of the programs have an office of their own.

Half of these offices are separate from any other agency, and were created just for the crisis service. The other half are maintained in some agency or office of the community.

Twenty-eight percent of the programs do not have any office space of their own, but have some direction, or involvement, from a clinic or hospital setting. In all, 59 percent of the programs have some administrative connection with another agency in the community; for 14 out of the 36 it is a health agency.

One program was established in the Community Services Center developed under an OEO grant.

(5) - Administrative Structure. The most frequent type of leadership for these centers is in the hands of a Board of Directors. These special advisory or governing boards have been created in 44 percent of the agencies; but fewer than one-fifth of them are directed by a clinic or hospital board of directors.

These facts regarding the agency history and organizational structure clearly support the observation which Harvey Resnik made when he pointed out that the professional groups have been relatively unattentive to the needs of the community for services to answer the cry for help. It is because of this vacuum that the lay citizen and the voluntary organizations have come in to fill the gap.

(6) - Manpower Patterns. We were, of course, very interested in the manpower or personnel practices in the programs. It was learned that two out of every three programs utilized the non-professional, or lay volunteer, in a direct patient service role. In 92 percent of the services using the non-professional, the workers function in a voluntary, i.e., unsalaried capacity; in some they are paid for their work.

It does not seem to require very many of these people to run a center because 61 percent of the services have fewer than 30 volunteers, and in 78 percent of the programs they are on duty fewer than eight hours a week.

While not all programs recognize the contribution of the trained volunteer, 100 percent of the crisis services surveyed involve a professional individual, in either a paid staff or non-staff, consultant capacity.

Professionals are on the paid staff and as non-staff consultants simultaneously in 56 percent of all the centers.

It is very interesting to note that the use of the professional as a consultant is much more frequent in those programs which use the volunteer for manpower. Ninety-six percent of them use the professional as a consultant.

But where the service is staffed only by professionals, consultants from the outside are utilized only 50 percent of the time.

There is still a great deal of information we would like to have about the procedures followed in these programs for the selection and training of volunteers. We know what methods are used in two or three centers here in Florida, but we want to make our body of data as large as possible, so we are going to try to get additional survey information in this area. This is important information, for I believe you will observe that those people who are threatened by the use of volunteers seem to behave as if they already knew what kind of training is given or not given; there is a tendency to operate on the basis of assumptions rather than facts. It would be good to know what really goes on in the selection and training practices of the crisis programs.

These manpower data show that suicide prevention programs are utilizing volunteers as crisis workers in a ratio of 2:1 over the professional as a primary treatment agent. This aspect of the community model is significantly in evidence all over the country. The popularity, and the feasibility, of this method has clearly been demonstrated.

(7) - Telephone Service. We asked the agencies to describe their clinical service. It was found that 100 percent of the programs maintain a 24-hour telephone; the calls come directly to the center in 75 percent of the programs. Some of them use a commercial answering service on weekends and "after hours", but only 25 percent use an answering service exclusively. It is the volunteer who takes the calls in 64 percent of the centers, and in 45 percent it is only the volunteer--no professional on the telephone at all.

(8) - Crisis Interviews. Over 70 percent of the centers conduct face-to-face interviews with the clients during the course of the crisis intervention work. Here the work is divided evenly with volunteers holding the interviews in half the centers and only professionals holding them in the other half.

(9) - Caseload. The centers report their caseload varies from as few as six new calls per month to as many as one thousand per month, but 60 percent of the programs have fewer than one hundred new cases per month. Eight percent report as many as four hundred per month.

(10) - Catchment area. It was of great interest to learn that most of these programs are established in only moderately sized communities. Only three programs serve areas of less than 100,000 people. Forty-four percent have catchment areas of less than 500,000.

It was also of interest to note that only 15 of the 36 programs knew what the suicide rate was in the area; 58 percent had no idea. The majority of the services evidently were not formed out of a motive for solving a public health problem. At least they don't seem to see the need for service in terms of the incidence of the problem in their area.

Of those centers that did report the local rate, only half of them said it was less than 15.0 per 100,000, which suggests that most programs are located in fairly high rate communities.

(11) - Scope of Services Rendered. Only 14 of the programs limited their service to suicide crisis cases. All of the rest stated they deal with a wide range of cases, including alcoholics, acute psychotics, general family crises; these conditions were cited specifically by over 85 percent of the programs.

Fifty-nine percent reported working with problems falling in the "miscellaneous personal crises" category.

Some programs replied, "we are not suicide prevention centers anyway, we are general crisis services". This, we thought, was a very appropriate response--except that there are only seven of them. Of these seven, four utilize supportive personnel, and three are staffed only by professionals.

Summary of Characteristics of Current Programs

If a hypothetical "average" center can be created out of these frequency data, it would look something like this:

a. It would have been established by the Mental Health Association and/or a local lay citizen playing the initiator role.

b. It would be financed by private, non-governmental contributions.

c. It would have begun its operation sometime after January, 1965.

d. It would be administered by a paid director, and probably also have an Advisory or Governing Board.

e. The program would have its own office space, either separately, or within a health agency of the community.

f. It would utilize trained volunteers as supportive personnel, to take telephone calls and hold face-to-face interviews, with professional persons serving both as consultants, and as paid staff colleagues.

g. It would operate a 24-hour telephone with calls answered in its office, as well as by volunteers in their own homes, through an answering service after hours.

h. It would serve fewer than 100 new cases per month in an area of less than one million population.

i. It would serve in a variety of personal and family crises, and would not limit itself to suicide prevention alone.

This, then, is the profile of over fifty formal programs currently operating in this country for the prevention of suicide. This is where we are at the present time in the efforts of local communities to provide emergency crisis intervention services to the public. The important question is where will we go from here.

The Development of Community Crisis Programs in the Future

As we survey the present scene in the arena of mental health programming two developments are emergent in rather clear focus. One, the citizens of local communities have taken up the challenge and have developed a system for delivering emergency crisis service to people who are distressed. Secondly, the states, in concert with the federal government, have launched a major health program to enable local communities to embrace all of their mental health needs, including emergency service for crisis intervention and suicide prevention.

It is inevitable, and it is imperative, that these two social actions should come together. Whether the result is a head-on clash, or a gentle integration, is going to be the result of thoughtful planning which must begin now. There will be comprehensive community mental health centers with emergency services. Whether or not there will continue to be suicide prevention programs as we know them now, or whether the valiant and pioneering efforts of the spirited citizens who are devoted to reducing the misery of their fellow human beings will pass out of existence remains to be seen. Are we on the threshhold of an entirely new era where the recently developed suicide prevention programs will prove to have been only a temporary stop gap? Or are we about to witness professional services willing to seek an assist from the work of volunteer organizers and lay crisis therapists?

The answer lies not in the appropriateness of the crisis situation to care from supportive personnel, nor in the ability of volunteers to render a therapeutic service. The answer lies rather in the attitudes of all the people involved, in their readiness for social and organizational change, and in their ability to serve as effective change agents.

Should communities continue to establish crisis intervention services as they have been, especially in the past three years? Or, should these

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efforts be discontinued, and a passive irresponsibility be rationalized as a judicious decision to wait for the comprehensive mental health program? There are a number of considerations in this issue.

In the first place, there is no doubt about the need of the comprehensive center for what the established suicide prevention program has to offer. No doubt at all. The greatest need is for trained manpower. A Construction Grant provides only a building; the program is tied to the Staffing Grant. Yet, a Staffing Grant provides only money for salaries, it doesn't provide, nor even promise, the availability of the people to cash the monthly paycheck. Therefore, if trained and experienced volunteer crisis workers are already available, and know how to utilize professional consultation, only the most wasteful and inept planning would prevent their utilization.

There is also the use of the suicide program that Dr. McPheeters and Mr. Haughton have commented upon. In the large multi-center areas, how many telephone numbers should be established for emergency service? No person can be expected to know which catchment area he lives in so he can seek emergency service by dialing the correct telephone number. But an existing crisis intervention service can very well be the coordinating and dispatching agency for the eight or nine comprehensive centers in Miami, or Atlanta; or even the three centers in Tampa. This would be a very valuable service to augment and implement the community mental health program.

However, the existing crisis program has certain problems it must face if it is to be of any value to the total community mental health program. It may have to submit to administrative and organizational change; it may need to be prepared to give up its own identity as an agency, or to have its image taken over by the broader community service.

Furthermore, a new crisis program will have certain problems in getting started. It may be that the more involved we become with the comprehensive program, the less interest will be shown in suicide prevention centers. There is sure to be little support or encouragement from the state mental health authorities. I am not referring to the lack of financial support only, but also moral support, encouragement, and acceptance may not be forthcoming. The states, quite naturally, see it within their domain to promote the establishment of all community mental health services, and they are not likely to be convinced that it should be done on a piece-meal basis. There is, of course, no quarrel with that. But the real danger is that local health leaders may want to reserve organizational energy for the comprehensive center development. They will forget that we have not been sitting by waiting for comprehensive center funds before we establish out-patient clinics, or general hospital wards for psychiatric patients, or half-way houses.

It will be an up-hill job for the initiators of crisis programs and they must be so determined to provide a needed health service that they are willing to risk seeing their product either swallowed up, or ignored out of existence, when the comprehensive center becomes a reality. Fortunately, there is a third alternative. It can happen, and it should happen, that joint planning and open-minded negotiation would result in a new crisis program so organized in the beginning that its maximum contribution to the eventual comprehensive mental health center could be realized, and its continued existence as a cooperating agency "not all under one roof" could be assured. Whether or not the social action planners in our communities will permit the accomplishment of these goals is something only the future can reveal.

There are already some examples of suicide programs operating within what are now, or will soon become, units of comprehensive mental health centers. Washington, D. C., San Mateo, California, Pacoima, California, Wyandotte County, Kansas and Brevard County, Florida offer prime examples. Here in Florida, in Brevard County, we have the first known example where a separately established community suicide prevention center dissolved itself to become a cooperative and integral part of the clinic which will become the focus of a comprehensive center. In the Brevard County program the suicide center provides not only trained volunteer manpower, but it serves as the nucleus around which the essential emergency service may develop.

Can it happen the same way in Orlando, Miami, Chattanooga, Atlanta, and St. Petersburg. What about the suicide centers that are being planned in Tampa, Jacksonville, Knoxville, Columbus, Nashville, Greenville, and Charleston? Will their planning cease in midstream in deference to the state program? Or can they move ahead to initiate a service which will both implement and compliment the establishment of a comprehensive center through a cooperative integration of purposes and activities?

I have been trying to convince you that our future course is already charted:

(1) We must continue to develop community crisis intervention services to deal with suicide, as well as with the whole range of personal and family crises of living. We must continue to experiment with various methods and techniques of organization for the delivery of emergency service.

(2) We must proceed in such a way as to permit the maximum contribution to the total community mental health program.

(3) We must develop programs around a pool of available volunteers, professional consultation, a network of agencies ready to facilitate one another, a focus on competency to meet the problems of living and the prevention of more serious psychiatric casualty, and an orientation toward self-evaluation research.

Summary

Many years ago there were some daring pioneers who began to develop suicide prevention centers. Some of them were not durable. Others were not very impressive, or could not be copied. So, other people began to develop new kinds of agencies; they were successful, and programs flourished. Then along came the comprehensive community mental health center. It promised to be the best of all, and maybe even to replace the previous programs. But will it be the best? Should it replace the others? Time and experience alone can write the last chapter to this story.

A similar tale was told recently by the cartoonist, Jules Feiffer. He put it this way:

> My dream has always been to have the world beat a path to my door. So, I built myself a mouse trap. And the world said, "A promising first effort, but unrealized."
>
> So I built myself a better mousetrap. And the world said, "Admittedly skillful, but lacks the power of his first mouse trap."
>
> So I built myself an even better mouse trap. And the world said, "A mouse trap best forgotten, especially when one recalls the uncommon skill of his earlier work."
>
> So I abandoned my attempt at building mouse traps. And I built myself a house to hide in. And the world beat a path to my door, and said:
>
> "Not nearly as good as his mouse traps."

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Reaction to Dr. McGee

Rufus Vaughn

It is somewhat difficult to respond to Dr. McGee's outline of program description. The primary value of the paper is clearly in its specific content, in that as new programs develop emerging patterns of care in the various communities become enormously important to the programmer. We must, of course, view each program from the standpoint of our own needs at a local level and can rarely transpose into one community a program developed in another. Principles and ideas can be transferred, but the translation into action must depend on local needs, local resources and local idiosyncrasies. I think it is unlikely that any program similar in detail to the Chattanooga program, just for example, will ever be developed.

I have shared with Dr. McGee on prior occasions my own concern about the development of suicide prevention centers. I also would hope that this movement can eventually merge with, and be combined with, the Comprehensive Community Mental Health Centers. Unless this is done there will inevitably be conflicts of interest and competition over staff and patients. It seems to me that the principles underlying approaches to suicide prevention are quite similar in many ways to crisis intervention in general. It is very difficult for me to separate these out as distinct problems. Because of this I have never been extraordinarily sympathetic to the development of suicide prevention centers as such.

This is in no way meant to denigrate the contributions made by those professionals working within suicide centers. Quite the contrary, these professionals have enlarged on the principles of crisis intervention and brought to a practical reality many of the extraordinary ideas outlined by Gerald Caplan and his group at Harvard.

There is, however, an area of concern to me when the use of volunteers is raised as a possible source of manpower. In my experience, volunteers have limited usefulness and require, unequivocally, continuing coordination. Volunteers may be available in large numbers at the beginning of any project but this number decreases so that eventually what happens with any group is that there forms a very small stable core of workers. I'm not at all sure that volunteers ultimately save staff time. We see this very clearly in a teaching setting with medical students, nurses and psychiatric residents in that ordinarily a well-trained psychiatrist can work much more efficiently, and easily accomplish the work of two or three psychiatric residents. The main value that I have seen in the utilization of volunteers is that it tends to develop increasing interest in some people, and stimulates them to seek further degrees of competence, and to pursue educational or personal goals which were previously not extant.

Dr. McGee in his paper has clearly realized his goal of bringing to our attention various problems in the development of centers. I believe we would do well to review these areas as we formulate our own plans and preparations for community mental health facilities.

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COORDINATION OF EMERGENCY SERVICES IN MULTI-CENTER AREAS

Anson B. Haughton

Within the past two years, a surprising number of Community Mental Health Centers have been established. We are coming to that point in time when we can observe the evolutionary process and growing pains of this first group of centers. We can begin to feed back useful information to centers now in the planning or implementation stage. It is also currently possible to see and understand more clearly some fundamental problems related to the establishment of centers, problems which could not have been adequately considered previously, principally because there was no prior experience or experimental data. One problem, which has been of special interest to the Center for Studies of Suicide Prevention at NIMH, relates to the situation created where three or more CMHC are established in a single metropolitan area. Before examining this special situation, just a brief word is in order as to the extent of the problem. There are approximately 30 cities in the U. S. which have populations of over 400,000 persons. Most, if not all, of these cities can anticipate the establishment of at least three Comprehensive Mental Health Centers within their metropolitan area. There are about ten cities which can project seven to twelve CMHCs in their urban areas. It seems obvious, therefore, that a considerable number of communities have, or can expect to have, three or more centers. Some of these cities will have quite a large number of centers. Let us turn then to the problem purportedly created by multiple centers in a given area and perhaps the heart of the matter can best be set forth by first examining the over-all objective of the CMHC program itself.

The Need for Coordination

Ideally, the CMHC concept envisions a community mental health program which provides total mental health services to meet the total needs of a community. There is a very important factor that must be kept in mind, however, when we consider a total program for an entire community. The booklet, The Community Mental Health Center, An Analysis of Existing Models, puts the matter thusly: "It cannot be overemphasized that the community mental health center movement seeks to accomplish comprehensive services not by duplicating or replacing existing services but rather by coordinating and improving what now exists and filling in the gaps. . . . It should be recognized that one of the stiffest challenges of the whole movement is the need for many agencies to coordinate now separate programs: this will require a magnitude of compromise and coordination that staggers the imagination."

If one examines the literature related to the CMHC movement, one finds repeated over and over again similar stress on coordination of services as being a primary and most important contribution of the "center" concept. Dr. Yolles, Director of NIMH, said recently in Atlanta:

> "Health Services across the land--traditionally--developed piecemeal to meet crisis or to serve the needs of specific groups within the community. And, as coordination was a rarity among other health services, it was almost non-existent among mental health services.
>
> "The fragmented approach to health and welfare services has been tried and found wanting. No matter how numerous may have been the services developed within a community--they have for the most part proven inadequate to the problem at hand. Their best efforts have been undermined by the lack of an essential ingredient: coordination of services.
>
> "The Centers program, then, is designed to inject the missing ingredient of coordination into the complex of existing services; it not only coordinates services into a unified network, but utilizes whenever possible existing facilities to provide continuity of care."

Coordination is, therefore, not only a basic substantive concept, but is, additionally, a fundamental and essential operational methodology for the program of each and every community mental health center.

Having, therefore, emphasized the importance of this element of coordination to what we might consider as a microcosm, that is, the individual CMHC, let us return to the macrocosm, the metropolitan area having three or more centers. You will recall that the concept of the CMHC ideally is that of a community mental health program that provides total mental health services to meet the total needs of the community.

Coordination Within the Macrocosm

Now it is possible to argue all day, or indeed for weeks, over what one means by the word community. For our purpose, the "community" of each CMHC is its "catchment area". In the large metropolitan areas that concern us, there is also, however, the total community of that entire metropolitan area. Our problem, therefore, revolves around a question as to the importance of the element of coordination for this macrocosm and the total community it represents. Considering the CMHC concept, we must therefore ask: Is coordination as important in providing total mental health services to meet the total needs of the macrocosm community as it apparently seemed to be essential to the design and working program of each of the separate microcosm centers?

Be assured, this is not simply an academic question and for several reasons. In the first place, as earlier demonstrated, the situation of multiple community mental health centers does or will exist in a large number of cities and metropolitan areas. Perhaps more significant is a second fact. In the over-all planning of the "centers" program, very little thinking has been devoted to the goals and designs that intra-center coordination would require. The lack of any information or experience made such advance planning very difficult.

It is the major thesis of this paper that coordination between individual Community Mental Health Centers, and coordination between these centers and all other health and welfare services, is just as essential for the implementation of the CMHC concept to the macrocosm of the metropolitan area as such coordination is considered to be basic to the goals and operation of a single CMHC. Something quite significant may be lost if in a metropolitan region, the several centers become isolated from each other--and from the other helping services--and as a consequence fail to develop between themselves some form of basic structure to provide communication and coordination; a structure which should perform for the region a role similar to that which the individual CMHC provides for its own catchment area. There is urgent need for research on the questions raised by this thesis and such research might well take the form of a demonstration project. It most certainly should examine the issues and should suggest guidelines that could be generalized to other cities.

A second major thesis of this paper considers coordination between centers--and between centers and other agencies--desirable in many areas; matters of personnel, clinical practices, general standards, etc.--but absolutely necessary for the development and effective implementation of certain substantive programs which relate more to the macrocosm than the microcosm. Let's consider certain specific examples, examples which are directly related to the fundamental responsibilities of all centers.

Consultation is one of the five necessary elements that must be provided by a CMHC. Many experts feel this element, in the long run, may be that innovative ingredient which will enable the Center concept to find its fullest potential. Consultation is that service which must be provided to the community at large: to the police, to school systems, to city planning boards, to the clergy, to parent teacher associations, perhaps to industry, perhaps to labor unions. Indeed, it is important not to define the limits of this consultation service too closely, just because this service must remain sensitive to changing situations which offer new opportunities for its skills. It must be able to modify its own structure, and indeed that of the center, when necessary, in order to adequately respond to new "areas of need."

It is quite probable, however, that much consultation by a particular CMHC will be to groups having a community identification not at all similar to, or compatible with, the "catchment" community of the center. The school administration system of a particular city may be highly centralized, for example. Individual centers will quite appropriately provide services to the schools in their respective catchment areas, but it seems rather undesirable that the school system be forced to negotiate over-all policy with each of a number of centers. How much more desirable that a single policy be worked out through the coordinated efforts of the several centers and the school system. Groups such as the firemen, the police, the medical association, the manufacturers' association, the chamber of commerce, and the ministerial association may well seek out or respond to consultation from a particular center. But for a variety of reasons, such consultation should proceed out of coordinated agreement between all of the centers. The lack of such coordinated policy can only be confusing to those seeking assistance, whether individuals or groups, and confusion can only impair communications and retard program goals.

Coordination of Emergency Services

In one area particularly, coordination between centers seems imperative. Full implementation of the emergency component of the CMHC concept will require maximum coordination both between centers and also between the centers and related facets of the total community. This is a third and last thesis and the one which will be the subject of the remainder of this discussion.

But before examining this thesis in its entirety, it might be helpful to first consider what are some of the implications of the phrase "full implementation of the emergency component of the Comprehensive Mental Health Center concept." A basic issue may be at stake here. On the other hand, what seems to be an issue may really only accentuate need for a more adequate definition. The dilemma appears to arise out of a rather simple question: "How broadly must the emergency facility of a CMHC interpret its responsibility to provide service to people in need?" The issue stems from the fact that the objectives and goals of the CMHC emergency component may be somewhat, or perhaps quite, different from those of the usual psychiatric hospital or clinic. In the usual psychiatric facility, the primary goal has traditionally been the diagnosis and treatment of psychiatric disorders. Where the presenting problem is not psychiatric and where another type of treatment service is considered desirable or appropriate for a particular client or patient recommendations may be given. The majority of mental health facilities, however, usually have assumed little responsibility for assisting in referrals, seemingly preferring that a client make his own contact with other agencies, presumably thereby demonstrating his motivation to be helped and incidentally his inherently good mental health.

It would seem that the CMHC mandate requires of both the micro- and the macrocosm not only the diagnosis and treatment of psychiatric disorders, but additionally an active and continuing involvement in providing assistance to people seeking all kinds of help. The person's needs may not be psychiatric, and appropriate referral resources may include a variety of medical, social, legal, welfare, or housing agencies. At issue or in question, therefore, is the extent of the responsibility of the CMHC to utilize its skills and resources in helping people get the help they need, even though the problems and the help they seek cannot be considered predominantly or even fundamentally psychiatric in nature. The issue emphasizes the subtle yet deep distinction between the terms psychiatric illness and mental health. There are indications that this issue is not easily resolved but it does seem that a straightforward definition as to CMHC responsibility in this area would greatly assist in its resolution where and when it appears.

Lacking such a definition, please keep in mind that the remainder of this discussion proceedings from two assumptions: (1) that each CMHC has a clear responsibility to provide the maximum possible emergency assistance to people; and (2) this broad responsibility is consistent with, and indeed essential to, the CMHC concept of a community mental health program providing total mental health services to meet the total needs of the community. Obviously, this goal is a very global one. On the other hand, the concept of the CMHC risks becoming encapsulated and its program largely emasculated if the totality of its responsibility is not fully realized.

At the core of the discussion is a conviction that the emergency component of a community mental health center does have definite responsibility and obligation to provide a general telephone answering and referral service for persons in crisis or emergency situations. Many of the crises and emergencies will have presenting problems that are psychiatric in nature. The referral, therefore, will be, quite appropriately, to the CMHC itself. In other cases, the emergency will not be primarily psychiatric but rather may be medical, social, legal or otherwise. It is a difficult proposition to keep abreast of the various community resources, medical, social, welfare, legal, etc., even in a small city of say 200,000 persons, the maximum size of a CMHC catchment area. It is, therefore, an increasingly difficult proposition to provide an intake and referral service for cities of 400,000, 800,000, or 1,500,000 persons. One might reasonably question whether this telephone referral service need be replicated in each CMHC in these large cities. Yet the responsibility for providing such a service is clear if the two original assumptions are accepted as valid. The importance of such a service cannot be over-stated. Very few professional health and welfare workers in major cities, let alone the average citizens, are aware of even a few of the helping resources available. For years, the police, the medical societies, the fire departments, and the telephone company have functioned in many towns and cities as makeshift sources of emergency information.

Centralized Telephone Answering

There is an alternative to the costly process of providing identical telephone answering and referral services for each of a number of CMHCs in a given metropolitan area. This alternative would provide for the establishment of a single centralized telephone answering and referral service for the entire metropolitan area. This centralized telephone answering and referral service would be sponsored and staffed through a coordinated effort by all of the centers in the area. In no way would such a centralized service compete with, or take the place of, the regular intake facility of each center.

If we really intend to overcome the piecement, fragmented approach to health and welfare services, referred to earlier by Dr. Yolles, we must start a process of true coordination. The first concrete expression of this coordination might well be such a centralized telephone emergency service which would have as its first task an inventory of the resources already available in a community and would then develop ways by which this information might readily be made available to persons in need. Is not such a task compatible with the responsibility of the CMHC? Should not the CMHC provide the leadership and skills necessary to implement this initial coordinated effort?

Comprehensive Inventory of Services

Let us examine briefly how such a centralized emergency service might function. Essentially, it is a matter of establishing adequate communication at a variety of levels: communication with the community resources; communication with the community itself; and, if this service is to be a joint effort of the CMHCs, complete communication between each of the centers. One of the first tasks that would have to be undertaken in order to effect communication with the community resources would be the establishment of the inventory of services mentioned above. While apparently simple, this is, actually, a complex, difficult and very important job. The inventory begins with the compilation of a list of agencies and a description of each of their functions, but such a static list is but a very preliminary effort. The really important part of the inventory process requires maybe several visits to each agency or facility. It requires taking the time to work through with each agency how it will use the centralized service, and the extent to which the centralized service can use the agency. This step, which is really a variation of the community organization process, accomplishes several very important functions. It is good public relations at a meaningful level. It provides the established agencies with an opportunity to ask and find out "what's in it for them" and removes or reduces fears that this new centralized referral service will swamp them with new cases. It gives the centralized service a chance to get a feeling for the working limits of intake and service followed by the established agency, the type of case and service it prefers, and the typical disposition made of accepted and rejected cases. This firsthand "learning session" provides the centralized referral agency with an opportunity to probe gently as to the flexibility of the established agency and to estimate the possibility that it might be willing to slightly modify its established policy in order to assist in meeting the emergency needs of the community. An example of such a modification is the arrangement worked out between some of the newly established suicide prevention and crisis programs and their local family service agencies. By this arrangement, the family service agency sets aside a certain number of professional hours each Monday. These hours can be assigned by the emergency service workers as needs arise over the weekend.

Of necessity, this inventory of community resources must be dynamic, that is, there must be adequate provision made for feeding back into the inventory the day-by-day changes that take place in the community resources--changes which affect, in many different ways, the relationship of the centralized agency with the older established ones. This inventory must be kept up to date.

Patterns of Communication

Assuming the establishment of the inventory described above, the next step in establishing a centralized emergency service requires developing lines of communication between the community and the service.

Relatively little is known about the various patterns of communication that may be found in human communities or perhaps equally important, the barriers that prevent communication. This is a most important area for research. City planners are not even sure how to describe or define what constitutes a basic or elemental community. How do people ask and get help? Under what circumstances do certain types of people of different backgrounds and socio-economic levels seek help, first through their accustomed patterns and, when these fail, through other less familiar ways? Some sociological studies are available but much more must be learned before we will understand how to reach out effectively to individuals in need whether in towns or rural areas.

Interest in this problem of how people communicate--specifically how they cry for help in a crisis or emergency--has been stimulated in recent years as the result of a rather remarkable phenomenon. Throughout the country in a considerable number of towns and cities, there have come into existence suicide prevention or crisis intervention programs. In this country, as you know, these services have usually generated out of a local concern often sparked by clergy or other caretaker groups, and have in most cases quickly established ties with professional health and welfare individuals or groups. An examination of the function of these services as they have developed in the United States reveals what is essentially an intake and referral service built around a 24-hour telephone answering unit.

Role of Established Suicide/Crisis Programs

The function and role of these suicide prevention telephone services seems most relevant to our discussion about a centralized emergency service. The experience of the suicide prevention program indicates that there is considerable need for a single telephone resource (or number) to which people can turn for accurate information, competent assistance in getting help, or support and understanding leading to a good referral. One of the unique factors that these suicide prevention/crisis intervention programs seem to have in common is a tendency to focus immediately on the person in trouble and his present situation rather than upon the type of problem he presents as defined by the typical health and welfare service. This focus on the person, while sometimes rather naive, may, at a primitive level, be more helpful prophylactically and therapeutically for the person in acute distress than many hours of highly professional skill at a later, less critical, time.

Although these suicide prevention/crisis intervention services seem to have recognized the importance of a quick response to a person in an emergency, they have, for the most part, been severely limited in their ability to place fully competent workers at the point of response. With few exceptions, budget restrictions and a lack of professional personnel have forced these programs to rely heavily on non-professional mental health workers who in most every case receive some type of pre- and in-service training. One may anticipate that in the long run, a combination of immediate response and skilled (professional) response will provide the best assistance to persons in critical life situations. It is precisely at this point, therefore, that there would seem to be a logical point of intersection between established suicide prevention/crisis intervention programs and the obligation of CMHCs to provide a broad type of intake and referral service.

Values of a Centralized Emergency Service

A centralized emergency telephone answering service seems an important first step toward several highly desirable objectives. Such a coordinating mechanism might provide a basis for communication between the CMHCs on a number of policy and program matters. The necessary inventory of community resources should open a host of communication links between the centers and these resources. The centralized emergency service would serve as an ideal data source for collecting and supplying information regarding various aspects of emergencies in the community.

It is obvious that such an elementary coordination effort cannot accomplish more than its designers choose to build into it. Care must be taken not to over-estimate the ability of the telephone to provide communication links with an entire community. One may expect that there are a number of persons in any community who do not find the telephone a natural extension of their right arm, and who, therefore, would not tend to use it in a crisis. Considerable investigation must be done on other modes of community communication and the various barriers--sociological, psychological, geographical, etc.--which act to impede communications.

Summary

In closing, I want to re-emphasize several assumptions and some conclusions which are, in part, based upon these assumptions:

(a) In a metropolitan area with several CMHCs, coordination between each of these centers is as important to the mental health objectives for the metropolitan area as coordination within each of the CMHCs is important to the mental health objectives for each of the catchment areas.

(b) Coordination between centers (and other agencies) is desirable for some service functions, but quite necessary in others, particularly emergency and crisis management.

(c) A skilled, competent telephone answering and referral service which can respond to all types of human emergencies should be a part of the emergency component of each CMHC except that, where there are three or more CMHCs in a metropolitan area, these centers should coordinate in effecting a centralized general emergency telephone service. This service should be sponsored by all the centers, and act as an extension of each.

(d) The suicide prevention/crisis intervention programs which have come into being in recent years throughout the U. S. function essentially as community emergency intake and referral services. Many of these programs have pioneered in establishing this type of intake and referral service; their inventory of community resources is sometimes the only, and often the most up-to-date, such inventory. Many of these suicide prevention/crisis intervention programs have strength and know-how that the emergency components of CMHCs coming into being cannot afford to overlook. It would seem that these programs and the CMHCs can each contribute greatly to the other. There is certainly no room for competition nor snobbishness. There are too many people needing help.

Coordination! Communication! These are the keystones of the Comprehensive Mental Health Center concept. The fact that a CMHC catchment area is limited to 200,000 persons creates problems of considerable magnitude in larger cities having three or more centers. Many of these problems arise out of an insufficiency of these same basic elements of coordination and communication. Lack of coordination between helping agencies and the people in need too often has been the cause of serious breakdowns in communication, and this is tragic. Communication is the essential and basic ingredient that brings together the helper and the helped.

Finally, we must be on our guard lest we overcome a deficiency in coordination at one level, but allow a lack of coordination to exist at another, and perhaps even more crucial level.

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Reaction to Mr. Haughton

Leonard L. Linden

The importance of this excellent paper by Anson Haughton is that it not only offers specific suggestions, but it directs general awareness to an aspect of the provision of emergency services that has tended to be neglected. Before reacting directly to the paper, it may be appropriate to call some background factors to your attention.

Despite the comparative recency of the establishment of Comprehensive Community Mental Health Centers, interest in community aspects of mental health and the study of many of its facets developed much earlier--at a time when psychiatry and clinical psychology were in their infancy. Most of the psychiatrists and clinical psychologists of this early period were oriented toward the individual rather than toward the community. Thus, virtually by default, the burden of exploration in this broad area was carried on almost exclusively within the discipline of sociology.

Illustrative of this early interest of sociologists is the classic study of suicide by Emile Durkheim. This work made monumental contributions to the epidemiology of suicide and to theoretical considerations of social factors involved in suicide. Unfortunately, an English translation of this investigation was not available until 1951, more than fifty years after it was originally published. By the 1920's and 1930's the works of Robert E. L. Faris, H. Warren Dunham, Calvin E. Schmid, R. S. Cavan, and Louis I. Dublin, to name just a few of the leaders, had made substantial contributions to our present knowledge of community mental health. In addition, several university departments of sociology were engaged in inventorying community organizations active in mental health and studying problems of coordination between them. Most notable among these was the Department of Sociology of the University of Chicago.

With this background in mind, we might ask what the paper you have just heard has contributed to our thinking about emergency services in Comprehensive Community Mental Health Centers. A large part of the answer may be found in looking at the disciplinary affiliations of the participants here in this meeting. The majority of you are psychiatrists, clinical psychologists, and other professionals directly concerned with the establishment and operation of emergency mental health services. The basic orientation of the represented disciplines is seldom concerned with the problem of coordination in the total community. It is thus understandable and significant that Haughton's paper represents the first explicit statement of the needs and problems of total community coordination that has been made to a group such as this.

Perhaps the best way of showing my appreciation of the importance of Haughton's paper would be for me to use my time expanding upon some of the points that may be considered to be implicit in his discussion.

The great public support for the development of Community Mental Health Centers, and particularly for the emergency services of the Community Mental Health Centers, is the result of the fact that the American public has suffered for too long a time with the splintered agencies that offer help in the field of mental health. Public acceptance of the Comprehensive Community Mental Health Center is based upon their understanding that the center will become a "mental health supermarket". The public is no longer willing to have to decide for itself which is the appropriate agency to call for help. Although they may be willing to go from building to building, or block to block, they don't want to be forced to fill out similar forms or answer the same basic questions for a number of agencies only to be told, "I am sorry, we don't service your denomination"; or, "I am sorry, you are outside our residential area"; or, "I am sorry, this is a family problem and we only treat children."

Given this public expectation of "mental health supermarkets," it would be disastrous to the Community Mental Health Center program if geographic boundaries and lack of coordination in multi-center communities continue to result in public frustration in their efforts to seek help. It would not be unusual in a metropolitan setting for a man to work in the geographical jurisdiction of one center and live in the jurisdiction of another. Where does he get service? Perhaps he prefers to receive treatment in the center closest to where he works, but his wife also should be seen. Does she have to come all the way downtown to be seen, even though there is a Community Mental Health Center near her? If these problems are not solved through coordination, there is the danger that the public will come to feel that you have perpetrated a fraud upon them. Unless coordination is successfully handled in multi-center communities, public support will boomerang and the Comprehensive Community Mental Health Center will become just one other agency in the community.

The very innovation of the concept of Comprehensive Community Mental Health necessitates further innovation in order to provide coordination of the needed services. Reciprocal professional staff privileges among the Centers existing in a community may help to alleviate the geographical problems noted above. The multiple collection of basic information could be minimized if all of the Centers in a community would use a central computer for storing this information. Thus, in an emergency situation it would not matter if the patient switched centers, the basic information would still be available almost instantaneously without inconveniencing the patient.

It may be time for us to ask ourselves exactly what we mean by emergency services. Are we talking about emergencies in terms of the patient or emergencies in terms of the agencies involved? I am thinking here of trends in the use of hospital emergency rooms. An increasing number of patients are seeking treatment in these facilities for conditions which are not medical emergencies, but for which they cannot readily obtain treatment elsewhere. Is this to be the role of emergency services of Comprehensive Community Mental Health Centers? Or should these emergency services confine their activities to actual crises in the life of the patient?

While we may still be debating and delineating the future role of emergency services of Community Mental Health Centers, the public has already developed their image of what this should be. The emergency services are to be the "all-night grocery" part of the "mental health supermarket". They are not interested in the problems of coordination; they are interested only in the results. Anson Haughton has given us some guidelines. We must be willing to follow them and expand upon them.

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PART II

MAJOR ADDRESSES

THE SOCIAL AND POLITICAL PARAMETERS OF THE PSYCHIATRIC EMERGENCY*

Bertram S. Brown
S. Eugene Long

How did I get to have a topic such as this--"Social and Political Parameters of the Psychiatric Emergency?" I'd like to trace some of the steps which brought me to it.

The first step was at Walter Reed in 1955, when I was between my third and fourth year in medical school. I had a clerkship, which is really a seduction program to get young medical students to look over Walter Reed and see whether they would join the Army for a medical career. This clerkship was a program innovation, in neurology and neurosurgery--it was an exciting educational experience that paid well. But I did not quite fit the system. They gave me one of these white coats with the Army brown caduceus on it. Realizing that I was not exactly part of the system, I went into all the cracks. They had a five-day course on nuclear war, nuclear medicine. You were not allowed in the classroom except with top security clearance, but I just walked in the door. It was a very exciting five day experience, because some of the most vital issues of the day were discussed. At that time--and it is rather chilling to think things have gotten much worse--they estimated something like 60,000,000 casualties out of 180,000,000 people. The question was: What would we do after an atomic attack? This was the subject considered by this predominantly medical and paramedical group. There quickly arose two groups and two points of view. The issue was triage--should there or should there not be a triage officer? After the bomb blast, should somebody take the sickest off to die? Or should the medical and paramedical groups treat the sickest? Some of the doctors who had gone through World War II (this was only 10 years later and the Korean War was very recent) felt that the whole Western ethic, the whole background of the medical model, the whole humanistic basis was that you had to treat the sickest first; you could not possibly, as a physician, ethically take the sickest and say they would die and treat only the lightly wounded. There was another group that said, "You are back in the last century; we will have a new situation; we will have a massive emergency; we will have to delineate out those people we can't treat with the resources we have available." This was a closed meeting, and the debate had a great effect on my thinking, through the fact that what defined the emergency--and the individual treatment of the emergency--was based on such things as the cold war between the United States and Russia, the armed forces of the United States, our security system, and what the scientific community knew about nuclear medicine at that particular time.

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*The second section of this paper, on The Social Impact of Change, was prepared collaboratively with Dr. Long.

In the course of dealing with this concept of mass emergency, other emergencies were looked at in depth. I was fortunate in having done some research on the Worcester tornado, and I remembered what happened in that particular mishap--the hospital services had been flooded by volunteers who wanted to give blood. There were hundreds of quarts of blood gathered, not one of which got to the emergency victims; they ended up in Philadelphia going to gamma globulin. Again, how to handle people who volunteer for service--who volunteer to help, who rise to the crisis--was an unanticipated and important dimension of the whole concept of crisis.

Fortunately, a year or so later in 1956, I had a chance to explore these concerns and concepts further. This was in New Haven at the Department of Pediatrics. I was a pediatrics intern, and had my rotation in the emergency room. You would have a situation in which there had obviously been a family fight, a terrible mishap, a crisis--what misery! And what did we learn? How to sew up the laceration. The social, familial, cultural, ethnic aspects of the situation were absolutely drilled out of your mind as an intern: you were told to sew up, to suture. This kind of procedure seemed sort of "crazy" to me.

Based on this rather one-sided training in how to handle emergencies, I started a research project. Very simply, this was to interview every child and his family who came into the hospital emergency room to see why he came, who referred him, what he was doing at the time of the mishap, and where he came from in town. I was fortunate to meet a Department of Sociology fellow named Hollingshead, and I also became close friends with a man named Harris Chaiklin, who at that time was a graduate student. We interviewed the child and his family to find out the background data. The questions were: What is an emergency? Why are you in the emergency room? Who defines it? Who sent you? What do you do about it? etc. The facts in our report, I think, are worth looking at. I will just read you the introduction. It says: "Social factors in medical care have been receiving increasing attention in the past few years. The physician, while maintaining his traditional interest in individual clinical problems, also wants to know the social background of the patients. One simple approach to the understanding of social factors is the analysis of the background of groups of patients who come to a particular medical facility. The purpose of the present report is to study the social background and its composition, and the reasons that a group of patients visited the pediatric emergency room of a large hospital." Let me tell you what I found by seeing every pediatric patient in that month.

First, looking at recent trends taking place in all the other hospitals in the United States, the number of visits to the pediatric emergency room had doubled in the previous five years. The upward trend from 1950 to 1955 had continued. This was causing much consternation. Sixty percent of the patients were one to three years of age. The first dramatic finding was that the number of Negro children was far out of proportion to their representation in the population. In New Haven, 4 percent of the population was Negro, but half of the patients in the emergency room were Negro.

I made the "big assumption" that it seemed likely that the Negro finds definite barriers to utilizing private physician care. I say it more simply now, but that was when I was simple-minded.

The patients were classified according to their reasons for using the emergency room. The largest group was composed of patients who used the emergency room instead of their family doctor and those who had never used a private physician. Patients referred to the emergency room by private physicians accounted for only one-third of the total admissions. Only 20 percent of the patients were medical emergencies or were seriously ill. The majority had upper respiratory infections. A special study was done on admissions between midnight and 8:00 A.M. to see whether the middle-of-the-night call was more truly an emergency than the day call. No differences in any medical category could be found between those seen between midnight and 8:00 A.M. and the day callers. I confess that I was unable to recognize at that time that parental anxiety was the key thing in bringing patients into the E. R. in the middle of the night. We did some analyses to see who the new patients were--the input group, the ones who made their first visit--as opposed to the repeaters, to find out who was feeding the new-patient group. Our analysis showed that it was the young children of the Negroes who used the E. R. for regular full-time care.

The implications of the study, and what happened as a result of it, led to the next step. First of all, the doctor who was handling the most difficult problems was the intern with no supervision. The most complex, acute crises, the most mixed-up situations, were handled by the intern--not by the resident; because the resident had graduated back into the hospital to take care of the pneumonias that showed up only one out of fifty-two times in the E. R. I presented these findings to grand rounds at the end of the year, and they changed the structure of the residency program so that a resident was on call full time in the E. R.

The large number of poor people--predominantly Negro--being seen for emergency service led to the concept, in terms of public health, that perhaps a Health Center with coordination of various health facilities was needed. In terms of hospital administration, the findings revealed very clearly a need to change some of the structures of the hospital in order to integrate its services to this group. For instance, there was no flow of information from the E. R. and follow-up care to the outpatient departments. The inclusion of additional information in the medical records system was another outcome of our research.

The next step occurred during my psychiatric residency, when I became involved in a program called the Community Extension Service. This was an outgrowth of a Title V Demonstration Grant from NIMH. The Community Extension Service was an attempt to take people off the waiting list of the Massachusetts Mental Health Center, the Boston Psychiatric Hospital. The method was to have a team of people who were willing to do home visits, to take telephone calls, and to get out in the community to see how much hospitalization could be prevented. The finding has pretty much become a part of common knowledge in the mental health field--namely, that half the people who would have come into the hospital never needed to come into the hospital. This was in 1960 or so. People are still discovering that if you are willing to work out in the community, and willing to work with family factors, and do home visits, and "get with" the scene, you can prevent the majority of hospitalizations. Every time people rediscover this, it is very meaningful, and I think it needs to be rediscovered every three months or so for at least the next six years.

The most important element in this finding was the movement away from the hospital out into the community to do home visiting. Of course, the home visitors began to get in touch with real life out there where an emergency is defined. I will never forget the visit I made to the seventeen-year-old boy who was locked in a bathroom threatening to take a bottle of pills. There were present not only the physician, the mother, the father, the neighbors, but also the fireman--who became the most difficult problem when he wanted to climb up a ladder to the bathroom window. This is what they sent a first year resident out to handle! The one they sent out was the one with the least experience--which was the right thing to do, as opposed to expecting the trained emergency room intern to cope with the problems faced in the previous situation mentioned. I won't tell you how I solved the problem of the boy in the bathroom who was going to take pills, but it came out all right.

The major point that comes to mind is this: Where you do your work--the locus of your work--may have a lot to do with how you define an emergency. That is, if you define it where people come in to you, whether it is a clinic or hospital, that is one thing. But if you define it out there where the real action is, you have a whole new set of factors. The phrase popular at that time--crisis intervention community work--became rather dramatic and important, a kind of prelude, the prodrome or labor pains to the mental health movement.

So, if one wanted to make some of these advances--to get out in the community, to deal with emergency, to deal with difficulties--what did it take? Several things. First of all, it took more money. Secondly, it would take a change in the laws, formal and informal. If one really wanted to change the situation to where you had to make decisions other than whether or not to hospitalize, there would have to be change in the legal structure, whether it was a formal or informal legal structure; and one would have to increase funding.

The Social Impact of Change

I want to introduce this evening a concept of the fourth dimension of program support. There are three classic dimensions: 1) standard people, 2) served at standard times and places, 3) by standard servers and services. The fourth dimension is the impact and implication of newness and change. That is, you see new types of people, at new times and places (like the middle of the night, and in their homes), and you offer them new types of services that they may never have received before. If you are going to do this, you need changes in the social and political parameters. You need new sanctions, new funds, changes in areas as diverse as the laws, and the attitudes of professional organizations.

Let's just take the economic aspect for a moment and see where it leads us in our thinking. Quite often, in saying where the community mental health program is going, I like to describe these two directions, the right and the left. To the right I describe large area regional medical programs, medical schools, universities, and heart disease or kidney centers--the regional medical program direction, to be very concrete. To the left I describe the smaller, neighborhood-based (in the midst of poverty, poor people, human misery), the OEO-type neighborhood service programs concept. Obviously, the right and the left--the regional medical programs, which involve catchment areas of a million, and the neighborhood service program concept, which involves catchment areas of 500 to 10,000--do not really exclude each other and are part of a continuing network. I am somewhat artificially putting them in two polarities. Take a look at two dimensions, two aspects or implications of these two directions. In the regional medical programs, the most dramatic activities take place in the kidney units and the coronary care units, which are really progressing, and are saving lives. Have you ever looked into the economics of a coronary care unit? Just add up how much it costs per life to save a life. Then, at the other extreme--the non-medical, psycho-social, humanistic concern, the *suicide prevention* center--take a look at what is spent there to save a life. It is rather "piddling" from the economics point of view compared to what it takes to save a life in the coronary care unit. Yet, the measure here is the one we all talk about seriously, philosophically, and politically--we talk about saving lives. I think a comparison of the economics of life saving along the suicide prevention dimension, and the coronary care dimension, would yield dramatic results in the political area, and such a comparison has not yet been made.

The legal parameters of emergency have to do with commitment laws, what an emergency is, how the States actually define it by law, etc. You find some very interesting things, familiar by osmosis to most of us. For example, the issue of "dangerousness" is the one theme in every law in every State. How do you define dangerousness, and where does dangerousness to others relate to dangerousness to self? The other aspect is the relationship of protecting a person's individual liberties to protecting society. Most interesting is the fact that institutionalization is still the major modality to which the law addresses itself. The decision-making process ends up with whether or not you remove the individual from society, a practice dating from the last century. Most of the activities that result from emergency commitment laws in most of our States have not yet incorporated the concept of what one would do extramurally out in the community with these individuals, other than excluding them from society.

I would like now to move to a different focus--namely, what do we have up to the present date in the way of information on the emergency services in the community mental health centers that have been funded? As you know, we have funded at this point close to 300 community mental health centers in 48 States. By regulation, every one of these has to have an emergency service. So we begin to see how laws can determine the pattern of services. What do we have in the way of emergency services in those nearly 300 centers? There are two types of information; one is the information you get from the application form, which is, after all, a promissory note; and the other type consists of what is really going on in the community. I am sharing with you impressions mainly from the documents and the narrative forms, and to a lesser extent, impressions of what is really going on out in the field. So I think my information, at the most, is loose, but it has its own value. Most of these centers will have emergency services. Let us look at where these services are located. In about half the grants the emergency services are located physically in the health center, or in the mental health inpatient services, in the general hospital emergency room, or are related in some way to the intramural component. In the remaining half, they are reported to be all over the place. Some are in the rehabilitation center, some in the counseling center, the psychological service clinic, some in the outpatient clinic, the day services, etc. I think it is quite interesting that if one were to study the pattern of development in relationship to the locus, one might find a very interesting set of developments in the types of emergency services that are programmed.

The situation gets even more interesting when you examine the narrative descriptions of the programs to discover that quite often applicants specifically include preventive considerations in their emergency services. In these applications, the interrelationship of emergency and prevention is described as being quite close, at least in terms of conceptual linkage. In fact, consultation and education and emergency services are often part of one "gestalt". Plans are being "spelled out" by which community "care takers" and general physicians will be prepared by education and consultative support to deal more effectively with emergencies. Thus, in these program consultations is an emergency service.

Other facets in emergency programs that show up in reviewing mental health center applications are concerned with specific approaches to emergencies--such as crisis intervention. Others have to do with specifically mentioned suicide prevention efforts which will be a part of the emergency service; others, with creative attempts to minimize manpower shortage or distance problems found in rural areas--usually through the use of telephone hook-ups or a hierarchical back-up system involving community caregivers, mental health professionals, the general physician, and other psychiatric resources. It must be said though, that emergency services in the typical mental health center application appear at this point to be less adequately described, less thought through than other aspects of the programs. In a sense, emergency services appear to be "taken for granted"--though we are becoming increasingly aware of the complexity of emergencies and the great significance of who deals with the emergency, where, and when.

I have recently tried to learn what is going on in relationship to training for work in psychiatric emergencies. I have asked the computer programmers; and interestingly enough, if you ask for information via the key words "training" and "emergency," you get a big fat zero as output. You must start looking in other places to find training activities involving psychiatric emergencies. For example, let's look at Dr. James Cathell's program in North Carolina where he functioned as a "wandering psychiatrist" and developed an itinerant consultation service for general practitioners in a rural area in the western part of the State. Descriptions of this program have been published in both professional journals and pharmaceutical magazines; I think it is particularly interesting for us to note how these services were given. All the consultation was not given directly--the telephone clearly emerged as the key instrument. Telephone communication has solved the problem of linking the community doctor and his consultant. Dr. Cathell, in the course of routine scheduled visits, accomplished a 25 percent reduction in patients to be admitted to the inpatient service. In this program we see more clearly some relationships between emergency and consultation services and the prevention of psychiatric emergencies by the strengthening of the community. I personally have the impression that it doesn't matter what was said over the phone; it was the availability of the phone that was significant, but I am not really sure about that. We do know that the addition of the communication link itself cuts down the hospital admission rate by 25 percent.

Another emergency service which has been funded through the NIMH Training Branch, is a part of the Community Child Psychiatry Training Program at the University of Cincinnati. Dr. Gilbert Morrison, a child psychiatrist who became interested in emergencies of a psychiatric nature, is now in charge of a children's emergency service, and a children's emergency center. In the emergency center training is actually being given to residents who deal with these crises--crises which vary from the ingestion of strange drugs, various psychological or psychiatric syndromes and psychotic symptoms, to family crises of various sorts.

The center also deals with "early access to clinc" cases in contrast with emergency room cases. Here also the emphasis is on rapid development of support and prevention of hospitalization.

Dr. Morrison's service also illustrates another feature of psychiatric emergency programs: they don't seem to stand still; they seem to move. We move in two directions--one, out into the community in developing earlier intervention and prevention services, and two, either into the hospital or out into the community via consultation programs. I suggest that the movement into the community is just a new version of what is more familiar to us--the development of liaison psychiatric services including consultation and education within hospital settings.

Another source of information about Institute activities related to psychiatric emergencies comes from the mental health program development conferences--such as this one--that have been held across the Nation. I will mention that during 1967 there have been some half-dozen conferences focusing on various aspects of emergency services--trying to define such services, trying to establish their relationship to total mental health services.

Two of these conferences were concerned specifically with emergencies--depression and suicide, and "the problem of dangerous behavior". Two conferences studied the problems of alcoholism, one aspect of which is certainly the emergency aspect. Another conference sought ways for "planning and implementing psychiatric services in a general hospital." Part of this conference considered the emergency aspects of patient care and ways of dealing with psychiatric emergencies in general hospital settings. Only one conference seems a little far removed from the topic of psychiatric emergencies--a conference that was concerned with the role of the school as a mental health resource.

The Institute is concerned not only directly, but indirectly, with psychiatric emergencies. In this latter area, it operates through career training programs in basic mental disciplines, and community mental health training programs, as well as in specific research projects and demonstration grants having to do with the development of crisis intervention services. One of these programs that comes to mind is Dr. Edward Stainbrook's crisis intervention program in Los Angeles. The principal aim of this program is the prevention of hospitalization in psychiatric emergencies. It is interesting to note that the almost steady rise in monthly number of patients seen is accompanied by a rise in percentage of the total number "given treatment without hospital admission". A 23 percent increase in patients applying for admission is accompanied by a 9 percent decrease in total voluntary and emergency admissions. Dr. Stainbrook has a continuing-education training grant for psychiatrists, psychologists, social workers and nurses. We mention this program primarily to illustrate further the way in which the psychiatric emergency area is indirectly but very significantly being dealt with in training programs, consultation programs, and implicitly within the organization of mental health services.

There is at the present time a great interest in the topic of depression and suicide. This is due in great part to the work of Dr. Edwin Shneidman, Director of the NIMH Center for Studies of Suicide Prevention. This is one of the most active foci within the Institute dealing with psychiatric emergencies, notwithstanding the specificity of its name. It has already been pointed out by the organizers of this conference that many suicide prevention centers are in fact evolving into psychiatric emergency centers--or it might be more aptly said, psycho-social emergency centers. And it has also been noted that suicide prevention centers are often the opening wedge for establishing a total comprehensive mental health program in the community. This conference itself is one of five types of programs for "gate-keeper" education, which have been stimulated and supported by the Center for Studies of Suicide Prevention during the past year. The title and content of this workshop is illustrative of the relationship between suicide prevention efforts and the general subject of psycho-social emergencies. It is almost impossible in a "service" setting to talk about suicide without also talking about other degrees and manifestations of psycho-social breakdown.

Let me move to the conclusion. Consider again the coronary care unit. You can conceptualize a coronary damage limitation by good early care as well as by the actual prevention of coronary artery disease. You are moving back in space and in time to try to prevent the emergency from occurring. The same sort of movement back in time is also applicable to psychiatric emergencies and to suicide and depression. But what is needed, in order to support this kind of change, is changes in sanctions. Changes in sanctions mean changes in laws, changes in monetary support, and shifting of monetary support. When you plan to change laws, and to influence where money goes, you are speaking about changes in the political process.

The mental health program has not gone as rapidly as we had hoped, even though it has gone rapidly. The relationships of the total world situation--politics, war, and defense--determine in part what we do in emergency services here in the United States today.

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SUICIDE: AN OVERVIEW OF A HEALTH AND SOCIAL PROBLEM

Louis I. Dublin

Millions of people, not only in America but all over the world, live agonized lives because they are mentally disturbed. For a variety of reasons they are unable to adjust either to the environment or to themselves. They are square pegs in round holes. They are always in trouble--as children, as youths, as adults. They constitute our number one job in the health and social work fields. Now, the suicides are a fraction (I might say a sizeable fraction) of these unadjusted people, and are perhaps the most appealing group in the entire lot. Fortunately, we have become aware of their needs, and at long last we are seriously concerned with meeting them. This is what this conference has been about. I propose in this talk tonight to take you on an excursion to observe with me the natural history of this major phenomenon in our midst.

It is very natural for me to make this type of an approach because that was essentially my training. I have been these 60 years in the field of public health, and have grown up with it. The epidemiological approach has been the one which has been followed, and very successfully, in the study and in the control of the infections, and of other health conditions. There is no reason why it should not be as rewarding in the study and ultimate control of suicide. And so I propose to take you as far as our knowledge will permit to take note of the extent of the ravages of this phenomenon and the particular groups that are most directly affected. We shall explore the factual differences in terms of sex, age, race, ethnic group, marital condition, geographical locations, economic status, religious affiliation, or the other variables which may singly or in their totality throw light on our particular problem. Please don't be overwhelmed; I am not going to wear you out with an intensive exploration of each of these aspects of suicide. We shall take a looksee and try to make some sense out of what we have seen, because these items have a bearing on the etiology of suicide.

While we are on the way, we may learn to what extent we must look also to the emotional resources of the individual. In other words, we are not going to limit ourselves to the environmental aspects of this problem, because we realize only too well that we are dealing with human beings and the reactions of disturbed invididuals. We may in that way discover the prime movers in the suicidal complex. And finally, on the basis of this knowledge, we shall briefly consider the steps that are being taken or could be taken to create a truly effective organization for suicide prevention. That is a good sized order.

Factual Aspects of Suicide

We shall, for the most part, limit ourselves to the facts in our own country, although incidentally we will examine some other data by way of contrast. Our most recent government reports indicate that somewhat over 20,000 completed suicides are recorded each year. But in view of the fact that many cases are still diagnosed as fatal accidents or as resulting from other causes, we know this is a minimum number. Specific investigations in

New York City and in Los Angeles and other places indicate that this underreporting may be as high as 25 or even 30 percent. So on that basis it is generally agreed that not 20,000, but 25,000 suicides a year is closer to the truth. There are serious estimates that put the figure higher. Suicide has been for some time one of the first causes of death by number. And at the younger ages, in the early adult years, it is second or third in order of importance. It is a serious problem among juniors and seniors in our colleges and in our graduate schools.

Nor is this all. In addition to these completed suicides, there are from 8 to 10 times as many uncompleted suicides or attempts. That means a minimum of some 200,000 attempts each year which swell the record. We are, therefore, concerned with a major souce of life waste and family disruption which literally cries out for remedial attention. And I might say in passing that I used that sentence nearly 40 years ago. But that was a voice crying in the wilderness. We are still crying, but it is being heard better now.

Sex Differences

Observe with me first some of the more interesting characteristics of the completed cases. They are much more common among men than women, in general about three times as common, and at the advanced stages of life, ten times as common. It is interesting to note in recent years the gap between the sexes has been greatly reduced in two countries with very high suicide rates, namely, in Japan and West Germany, where living conditions were greatly disturbed in the last war and in the years following. This is a significant point to keep in mind. In Japan there was more than appears on the surface. There was a concentration of cases at the younger ages and of women at these ages. In Germany, particularly in West Berlin, the rate went through the roof--40 to 45 per hundred thousand.

Age

Age is a remarkably consistent variable in both sexes. Few suicides occur before age 15. But from this point onward the age curve is very characteristic. It is a curve that immediately tells you what you are looking at; it doesn't quite resemble other age curves. Once you begin to get a serious suicidal situation, let's say at ages 15 to 19, from that point onward the rate at each age period rises to the next by something like 50 percent, until the maximum is reached in advanced old age in men, and at about 65 in women, declining thereafter. It is an exponential curve.

Race

Color is another significant variable, the whites showing rates close to three times as high as for the colored. This difference, however, is beginning to diminish as the Negro is moving northward into the crowded cities and changing his way of life accordingly. I may say that in view of the increasing turbulence being experienced in a lot of Negro communities, I am fairly certain that the suicide rate among the colored will approach that among their white neighbors.

Attempted Suicides

From the facts listed thus far it is fair to say that completed suicide is primarily a white man's problem and is heavily concentrated at his older ages. That does not mean there isn't a suicide problem at other ages and among women. The many more incomplete or so-called attempted suicides present a totally different picture. First, it is the women that outnumber the men three to one. There has been a reversal of nine times; three to one in the completed cases for the men, and three to one for attempts among the women. Second, the great majority of these attempters are young people, rather than the middle aged or old; and finally, there is now a sizeable concentration of the colored among them and there will be more. These differences in composition of the two groups, the suicides and the attempters, suggest that the latter are differently intended, and that many of them are really attention seekers crying for help to relieve distress of one sort or another. This is also often indicated by the less lethal methods that they employ, and the pains they take to be discovered in time, to be found by someone who can help them. Nevertheless, they often do not achieve their goal, and when discovered it may be too late. Some authorities believe that the attempters as a class differ essentially in their personality from those who succeed. Of course there is much overlapping in the main characteristics of the two groups. The differences stem from the differences in the basic intentions of the individuals.

Marital Status

Marital status is a very interesting variable and throws a great deal of light on the problem. The lowest incidence is found, as one might expect, among the married, and especially among those who have children. The highest incidence is among the divorced, with the single and the widowed between the two extremes. Those whose marriages have failed apparently are less well equipped to maintain normal human relationships and to adjust to life's difficulties.

Socio-economic Factors

How about economic conditions? Here the answers are not as clearcut. It is apparently not the level of wealth which determines, but rather the effect of rapid changes which play an important role. Thus, in times like the early 'thirties, when the stock market collapsed, it was among those who had suddenly become impoverished that suicide greatly increased. It was not so among the chronic poor; they had already adjusted to a way of life which the depression scarcely changed. More light is thrown by the social rather than the economic status. Thus, as a regular condition in good times and in bad it is among the professionals and the highest ranks of business, the top of the occupational ladder, that the suicide risk is highest. It is lowest among the artisans and the agricultural laborers, but very high again among the unskilled, the unemployed and the unemployables.

Method of Suicide

Additional light on suicide is cast by the methods used. In our country, the outstanding fact is the ever increasing use of firearms. This is particularly true for men; more than half the male suicides are currently so accomplished. Among the women, the leading method is poisoning and asphyxiation, largely through the ingestion of barbiturates. Men are more likely to use violence, which is more certain of success. Women choose less violent methods, which also leave a larger margin for rescue. Also such methods are less disfiguring. This helps, incidentally, to explain the disproportionately greater number of female attempters.

In the European countries, the picture is somewhat different. In England, Denmark, and Sweden, the principal method is by poisoning, particularly with the increasing use of barbiturates. Firearms are rarely resorted to, reflecting the different national traditions of these countries in terms of violence.

Sometimes the methods used are fantastic, and reveal the underlying mental state which is driving the victim to such extremes, as when several methods are involved, so that if one failed the others are counted on to do the job. And then there are such interesting cases as these: When the suicide is arranged by jumping from an airplane in flight, or from the highest tower of a bridge, or from the top story of a skyscraper. Sometimes these people leave a note reading (and this is an authentic note): "Now the papers will have to tell my story". And the papers certainly do. They fulfilled the consuming wish which had eluded the victim throughout his life.

Social Disruption

Another item of interest is the influence of war. Contrary to what might be expected, the incidence declines markedly in wartimes. In both World Wars and among all participating countries, the suicides dropped to low levels, not only in the participating but in the occupied countries--in Holland, Belgium, and in Norway. These people had a terrible time during the occupation, but down went the suicide rate. However low it had been before the war, it reached bottom during the war period. This has been observed for a long time, and has resulted in some interesting speculations as to the causative factors in suicide. The sociologists see in this phenomenon the operation of the powerful integrating forces of society. During war years men and women alike are less concerned with their own difficulties and absorb themselves in the common good. Everyone is concerned with larger interests. People are more fully employed and feel more needed. At the same time, the psychiatrists put their finger in the pie too, and they remind us that in war time the aggressions which are so often directed against oneself find an outlet against the common enemy. That, too, is an impressive argument. It is noteworthy, however, that the professional military are particularly prone to suicide. Those who make war their business suffer from a very serious occupational hazard. They suicide pretty close to the top of the list.

Religion

Religious affiliation is another potent influence in the suicidal situation. Where the authority of the church is strong, the prevalence of suicide is indeed low, as is seen in the rates for Catholic Ireland, Spain, and Italy, and especially in the Latin American countries. I know their figures are unreliable, but they are so low that even if you increase them two- or three-fold they would still be very low in comparison to figures for other parts of the Western world. Here the doctrines of the church that suicide is a deadly sin, and the power of the clergy over the daily lives of the people are both very effective safeguards. On the other hand, where the people control their own lives and the power of the religious organizations is rather tenuous, the suicide rates mount to high levels, and sometimes very high levels. We see this operating in the Scandinavian countries. And here is an interesting item: in previously Catholic countries like Czechoslovakia and Hungary, where under the new communism, church authority has been destroyed, at the same time the suicide rate has gone through the roof.

The history of suicide among the Jews is particularly instructive. Under the old conditions when they were forced to fall back on their own traditions, suicide was a rare phenomenon among them. With the coming of the Enlightenment, more particularly in Germany, and with the increased opportunities to mingle with their Christian neighbors and participate in the social and intellectual activities of their countries, the rates among them rose, but were still lower than those of their Protestant neighbors. It was only during the periods of oppression and persecution that their suicide rates mounted, and finally in the years of the Hitler horrors, suicide became an everyday way out of their impending doom in the extermination camps. In the camps themselves, there was apparently little overt suicide--one of the most extraordinary facts I know. I talked with two physicians in Israel, both well trained psychiatrists, who had been in the camps and somehow survived them. Although they had not had any contact with each other, they both agreed that they never saw a case of suicide in their camp, which was a very large one. Apparently what happened there was that the unfortunates simply withdrew from life; they got off into a corner and lay there and did nothing; or they had not enough energy to take any violent measures to end their misery. And here is the payoff. It was only after the Nazi defeat when the camps were opened and these people were restored in health and given a chance to live again that they realized the horror through which they had passed. Then the suicides began among them, and there were many. It became a problem in Israel after these people arrived there. What these two doctors said to me was (perhaps they were speculating) in effect that these people were simply expressing their feeling that life was not worth living in a world where such an experience as their's was possible. They had gone through hell, and this was not the kind of world worth living in.

Theoretical Aspects of Suicide

There is much to learn from the facts that I have just presented. Obviously, these environmental influences are important in accounting for some aspect or some phase, of this suicide problem. But are they sufficient?

Some sociologists would have us believe that they are. The great Durkheim and many of his followers evidently felt so. I speak of Durkheim with great reverence. His volume, Le Suicide, was published in 1897, and he showed us the way, he outlined the pattern of study. His was a first rate scientific mind and he approached this problem with the thoroughness of a well-trained scholar. In his judgment, suicide was understandable in terms of the structure of society and not preeminently as a response to the characteristics of the individual. He realized that there were characteristics of the individual, but they were not paramount. It was the pressure of the outside that did the trick. Suicide is low where the social structure is strong. It is high where the social structure is weak. It is the degree of integration that determines. You notice I am not using the word "cause". They did not either; neither Durkheim nor the rest of them. But they did consider the degree of the relationship of the individual to his unfavorable environment sufficient to set the suicidal process into motion. They did not take into account the developments of modern psychiatry and psychology. We must not forget Freud and his successors who were writing and thinking at about the same time. These scholars pointed out the obvious fact that only a small fraction react violently to their unfavorable environment, and that these usually have a history of emotional conflict of long duration. These stem largely from obsessive fears and anxieties and feelings of helpless inadequacy, with their concommitant of hatred and aggressiveness. It is these basic emotional factors, they insisted, that drive the victims to suicide when the agonizing pressures from without produce the final crises which they cannot master as normal people can.

I am not a psychiatrist nor a psychologist, and I will not attempt to explore the dark recesses of these specialties. Experience has taught me, however, that there are valued insights in the views of sociologists and the psychiatrists and the psychologists. All of them must be given thought in our effort to understand and master the problem of suicide. Through such experience we now know that the situation is remediable, and that brings us to what this conference is concerned with--how we may proceed henceforward in our national effort to mitigate and ultimately to control suicide as a cause of death and as an even more serious problem of disability, and of community and family disruption.

Practical Aspects of Suicide

Utilization of Non-Professionals

On the whole, our efforts to date have been developed by necessity and our good common sense. Because of the scarcity of psychiatrists--and I may also add in all fairness their general indifference to the problem--the leadership in the movement has fallen into other hands, namely, of clergymen, social workers, and interested private citizens. That was the case in the early developments in Prague and later in Vienna. The latter center, sponsored by the Ethical Society, was particularly significant. I call your attention to the fact that the operation in Vienna began in the late twenties. It demonstrated that much could be accomplished by ministering to the most pressing needs of those in distress. The social workers and the friendly visitors were the key people. The few professionals--that is, the psychiatrists--served only as guides. It was one of the many misfortunes of the Hitler regime that it put an end to this effort and forced the leaders to flee for their lives. But the important lesson had been learned. At the end of the war the Catholic charities of Vienna took over where the Ethical Society had left off, and with the prestige and guidance of the psychiatrists of the medical center at the University, it established techniques and standards which have inspired most of the efforts for suicide prevention centers ever since.

But I must not forget the important work of the Reverend Chad Varah of London and his associates in the Samaritans; for they too have made a significant contribution. Their efforts seemed to have arisen quite independently of those in Vienna. Varah tells us that in 1953 he responded personally and spontaneously to the many cases of suicides, both completed and attempts, which were being reported in the London press. He wished to help these people before they engaged in violence to themselves. With the help of the press and the radio he offered his personal services. The response was immediate, and more than he alone could handle. He soon found ready helpers among his parishioners. Out of this simple, almost pathetically simple, beginning has grown in the last 14 years the largest, and I believe the most successful suicide prevention effort in the world, reaching thousands of people each year with services radiating from 58 centers in every part of England, Wales and Scotland, as well as in other parts of the Commonwealth.

The success of this organization stems from its simplicity, its boldness, and its directness. Varah first conceived the 24 hour telephone service. Then he discovered the latent power in his lay helpers, those who shared with him the immediate contact with those who came in response to his call. All of them learned with him by trial and error and perfected their techniques. And in his recent book he tells us of his errors. They soon discovered the variety of social agencies in London, how these could take over and help. They learned how to utilize the professional medical services when these were needed. But the essential thing that Varah and his fellow Samaritans discovered, and have taught us, was the great good that friendly, devoted people who cared could render to those in distress. This, in essence, is the lesson that lay volunteers properly selected and trained--and not over-selected and not over-trained--can learn and become the heart of an effective suicide prevention center.

In this country, the movement for suicide prevention was slow and sluggish in its beginning. In fact, it was only in the early fifties that the NIMH began seriously to advance it. It supported, by a long term grant, the basic work of the young psychologists, Shneidman and Farberow in Los Angeles. This was first essentially a research effort to disclose the factors involved in the suicidal process. Later the operation was expanded to set up experimentally a clinical center where service could be rendered to those who called for help. Here standards of operation were developed together with manuals based on the increased experience with clients. While at the beginning, the work was largely in the hands of professional workers, psychiatrists, psychologists and social workers, it has in recent years turned to training and using volunteers. It is today recognized as our leading suicide prevention center, and a focus for the country where training for leadership and service in new centers can best be obtained.

Organization

The investment the NIMH made ten years ago has paid off. In fact, one of its leading spirits, Dr. Shneidman, is now at the NIMH to guide the movement of suicide prevention which has taken hold all over the country. Already, well over 40 centers are in operation and all of them owe very much to the men in Los Angeles for the training of their personnel and the guidance they have received. These more than 40 centers have as yet no set pattern. They have been organized in a variety of ways and under a variety of auspices. Some are operated as extensions of state mental hospitals and community mental health clinics; and a very few by the public health departments. These are essentially community oriented operations. A larger number in recent years have sprung up under the lay auspices of local mental health associations. And the burden of the service is carried by non-professional volunteers with some professional guidance at headquarters. There are thus at this early stage a number of models, and this is perhaps just as well, it is as yet premature for the movement to jell and become standardized in its organization and operation.

Whatever be the form of organization, it will be well to keep in mind two essentials: First, the center must associate itself with and utilize all the health and welfare agencies of the community, official and voluntary. Furthermore, this must be reflected in the composition of the board of directors and the advisory board of the center. The second point to keep in mind is that the center should make provision for the study and evaluation of its experience. This means that each center will keep a meaningful record of its clientele, the service rendered to them, and then to follow them up at regular intervals to determine their current status. We really do not know what has happened to these people who have gone through the prevention centers. Perhaps on good ground we have assumed that very few of them have finally succumbed by the suicide route. We have all said so, and perhaps it is true. But do we really know? Perhaps too little time has elapsed and we have really made too little effort to find out what the experience has been to date. With the current development, it is now an essential part of the operation that we make provision to know. Our record keeping must therefore be better organized. The volunteers must be instructed to keep the record of their contact with clients up to date and these facts posted regularly on the summary sheet for each client in the central office.

Financing

One of the major problems still unsolved is that of the financing for these centers. Heretofore the NIMH has acted as the foster parent to get the centers launched and running for a few years. But that is obviously not the answer. What is needed is a solid base of permanent financing, which by its very nature must be local, and must be continuous. Certainly the usual method of financing through voluntary contributions by interested citizens is altogether too precarious. Even our limited experience has taught us that the support must come as a regular budgeted item of government. At one time I thought that the best plan was for a suicide prevention center to be taken up as a function of local health departments. There was already sufficient warrant in law which put the responsibility for combatting premature death and disability from suicide in such departments, just as had been done with tuberculosis and other conditions. But the response from the health departments was reluctant and miserly. That was most unfortunate--unfortunate because even 40 years ago when this cry first became audible, the health departments were, in every county of the United States, a going concern operating under law and with budgets and with staff. Don't forget the most important item of them all--visiting nurses, public health nurses; and in many health departments, affiliation with social agencies. In other words, it could have been done, and if they had taken hold we would now be 30 years ahead in the game. But they missed the boat. Well, that is history.

Fortunately, with the recent development of mental health work under the auspices of the states, and now with the new federal legislation for the organization of local mental health clinics, the way seems to be open promisingly in this new direction. The future suicide prevention centers will, in all probability, develop as arms of these mental health centers, articulated with them and supported by them. It must be hoped, however--and this is a pious hope--that the centers under such auspices will not curtail their relations with the non-official voluntary agencies, nor their full utilization of the lay volunteers. Once the suicide prevention center becomes a part of the local mental health center, and is run by the professionals, they must not give exit to that mighty arm of the lay volunteer who has made good, and has proved his worth. That must not happen. The centers must retain their simple, non-bureaucratic structure to be truly effective. I sincerely hope that such a solution will not only assure the permanence and growth of our suicide prevention movement, but that this very association will strengthen the entire mental health development. The very procedures of the suicide prevention centers, as they have taken shape over the last ten or fifteen years, can be absorbed with great benefit by the new Comprehensive Community Mental Health Centers. It is a two-way street now. These too will advance as they stay close to the grass roots, and are broadly administered as social as well as medical service units, and tap all the generous impulses of our communities.

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NEW DIRECTIONS FOR SUICIDE PREVENTION CENTERS

Edwin S. Shneidman

It is customary to begin the discussion of this lugubrious subject by citing some statistics. Less than a decade ago, there were three suicide prevention centers in this country; eight years ago, in 1959, there were four; seven years ago, in 1960, there were five; four years ago there were nine; in 1965, there were fifteen; two years ago there were thirty-three; last year there were forty-nine; now there are almost sixty; and the trend is up. These almost sixty centers are located in seventeen states.

One other statistic: In the ten years prior to 1967, there were three grants given by NIMH directly in the field of suicide prevention. In the last year, we have processed over thirty grants. It is evident from these and other data that we stand on the threshold of a burgeoning of growth and interest in suicide prevention.

There are, I believe, at least five trends or new directions in the current scene. The key words for them are: "locus", "activities", "dimensions", "diversity", and "professionalism". Let us address ourselves briefly to each.

Locus of Suicide Prevention Services.

It is evident that there is a shift in the locus of suicide prevention services. It would appear that the trend we see from the statistics just cited will not continue in this form. Rather, there will be a leveling off, not of activity, but of number of this specific kind of facility. I think that we will soon see the growth of suicide prevention activities imbedded in a variety of other settings. This is what is meant by a shift in the locus. There is no question but that this will be done in large part in mental health units; in some part, in the Comprehensive Community Mental Health Centers. There will be liaison and communication with other agencies within the community. The first steps of birth and visibility have been taken. The goal now is not simply to add to numbers of separate suicide prevention centers. What is really important is to save lives, and concomitantly to learn more about the phenomena of self-destruction in man. It should not make a bit of difference what the locus of these activities is. At the same time that suicide prevention interests are developing, there are other major threads in mental health. It would seem that suicide prevention activities will become part of these other major threads, particularly the Comprehensive Community Mental Health Centers.

Activities of Suicide Prevention Services.

The second new direction is that of combining suicide prevention services with other activities, specifically, the activities of training and research. In our brief history as individuals concerned with suicide prevention, we have already passed the point where we can be interested solely in service; there will need to be tripartite centers. These three aspects will have to do with simultaneous training, research and service. It is impossible to give service without talking to others, sharing your skills, diluting your anxieties, calling in resources, having relationships with other personnel, expanding your impact--and all of this under the purview of training. One cannot give service without giving training. And, an active mind cannot give service without in every contact with every person he sees, every hour he spends, not being bedeviled by running hypotheses; that is the groundwork of research.

There is a great deal to be said, of course, for structure, supervision, coordination and formalization of forms and procedures, which sets itself against waste and duplication. However, there is also something to be said for independence, autonomy, the unique approach, which sometimes makes for progress and efficiency. The balance between dependence and independence is one contained within the maturation of the personnel.

Dimensions in the Growth of Suicide Prevention Services.

The third trend is that suicide prevention services will involve new concepts and dimensions. For example, there is currently a great emphasis on the dyad. The dyad--the study of two-person interaction--is perhaps one of the most important single topics of psychology and psychiatry. The obvious extension or implication of this is that one does not deal with the suicidal person alone, but with him and his significant others. One treats them as a unit; and even more of them as a unit, even the family. It is pointless to call him in and mollify his perturbation, only to send him tranquilly out of your office, if he goes back to her and she undoes the good in a few minutes. One might as well face her and work it out and see indeed if she is a resource or a suicidogenic liability, in which case you will have to separate them. Initially, you need to treat the dyad.

Another new dimension is the movement from couch to town. This has to do with active therapy and our overcoming, in the last decade or so, our own fears and our own conceptual constraints. We now go into the community. We need to act more and more in our community. A suicide prevention center cannot function unless it integrates with the community and uses the resources of the community. No one of importance in the power structure of a community should be surprised that a suicide prevention center has begun to operate. One should contact the Mayor's office, the police, the local University, the Board of Education, the health officers, the county coroner, and many others. One does not open a suicide prevention center like a supermarket. The newspapers need to know about you. This contact is necessary so you can have your hand on the rheostat of the publicity. They can either laugh you out of the business or they can announce you prematurely. If they put your telephone number in the newspaper and you are not open, then you are in trouble. You are a community service, and you cannot be disdainful of any other groups in the community. If you really know your community, you can pick your way among elements of the power structures, carefully eschewing some and working closely with others.

Professionalism in Suicide Prevention Services.

Another major new dimension is the use of total resources of the community. It has been said by many that the biggest waste in this country is the unused woman-power. There are figures in every community that indicate that in most communities there are women in the homes who have M.D.'s, M.S.W.'s, B.A.'s, children and all sorts of intuitions and trainings and noble impulses, and who are available and willing to be involved. It makes no sense to disregard this major resource or any other source of volunteer, non-professional help within the community.

Diversity in Suicide Prevention Services.

Another new direction in suicide prevention services to be recognized is its catholicity. It is a socio-psychological, medical, forensic discipline. All these aspects are in suicide prevention services. We have talked about treating the individual and the dyad, and the need to know your community. There is also the need to attend to the legal side of suicide prevention, without over-attending to those aspects. This includes malpractice insurance, having legal coverage as that involves medical coverage. One needs a good working relationship with the police. You tell the police that if they have to break into a house in order to save a citizen's life, that you will be responsible. And you will have to mean it. You have to be willing to go to court. But it won't happen. If you in good conscience exercise your trained judgment in believing that a citizen is in mortal danger, then you are in an unassailable position. Indeed, you are in an unconscionable position not to do it. It is like jumping into a river to save somebody. You don't then think about the law. The legalisms assume their proper role when you understand what your mission is.

In suicide prevention, we are dealing with life and death issues. We are talking about the inimical aspect of man, the dark side of human nature, all of man's perturbations. What would make a man psychotic, and beat his wife, and batter his child. Suicide preventers must, in the last analysis, be philosophers. We are really dealing, I think, with philosophical issues, which include sociological, legal, social, and moral aspects of behavior.

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PART III

WORKSHOP GROUP REPORTS

Introduction

The six workshop reports which are found in the following pages have been divided into three sections. Each is conceived, and has been included, to serve a distinct purpose in these proceedings.

First, there is a statement of orientation, which was prepared in advance of the conference. Its purpose was originally to formulate the particular problem to which the work group was asked to address itself. These statements relate some of the background considerations of the problem, and thereby generally set the stage for the deliberations which followed. They were intended to charge the group to come forth with some substantive response to one general problem, and several related, corollary questions.

These questions were offered to the workshop participants as a partial list of the important areas of concern, around which thoughtful planning and, in some communities, active implementation might be initiated as a direct result of the Conference. They are included here in order to achieve an even wider distribution of these topics throughout the national community of mental health program planners.

The second section of each work group report is the actual feedback presentation which the Chairman made to the Conference at large. This is the message wherein each group revealed what they actually did with their task, and where any recommendations generated by the discussion periods were made. In most cases the group reporters presented both the content of their discussions and the process of interaction within the group.

Finally, a third section has been included in each group report. This portion is labeled "Summary of Concerns in the Group," which may be a presumptious, but hopefully accurate, description of the material. Each of the work groups enjoyed the services of a Recorder who, in every case, was a Clinical Psychology Intern. The interns' function was to tape record each session of the work group and, using the tapes, to assist the Chairman in the preparation of his feedback report to the final session of the Conference. The recordings, however, provided still a further advantage in that they enabled an analysis of the specific details which may have been lost in the general overview or summary reported by the Chairman.

There are several ways one may express a concern which he feels either personally or as a representative of a particular community planning group. A typical way is to simply ask a question, which usually includes an elaboration of why the question is being asked. A second frequent method is to make a statement which, because of its partial irrelevance to the context, reveals the anxiety energized nature of the speaker's intent. Still a third way to reflect specific concerns in a group is seen in persistent repetitions of a single dominant theme. All of these communication behaviors were present in each group.

Therefore, each Intern carefully analyzed and edited all of the tapes of his group sessions and noted in a simple enumeration the specific concerns of the group members. As often as possible the words used in this section are those of the group members.

The purpose of adding this section to the reports is two-fold. First, it serves to write into the official proceedings a record of the specific concerns of individual persons who are at work developing programs in local communities. It is usually an advantage for consultants and other representatives of State and national mental health programs to know what the local community is really interested in, and it sometimes can happen that the real concerns are not the ones which are apparent in formal mental health center grant negotiations. Perhaps there is some new grist for the mill which may provide fresh insights in the relationships between government agencies and local citizens.

Secondly, knowing what specific concerns have been expressed by those who are already wrestling with these matters may, in some small way, guide the thinking of new groups, as well as lend an assurance that they are not faced with problems of a unique, and therefore more unmanageable sort. There is a degree of security, sometimes even encouragement, in the knowledge that our most trying local dilemmas are, in fact, ubiquitous in the community mental health arena.

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WORKSHOP GROUP "A"

THE NATURE OF A COMPREHENSIVE EMERGENCY PSYCHIATRIC SERVICE

Chairman: THOMAS S. RAY
Resource: HAROLD L. McPHEETERS

* * * Task Orienting Statement * * *

It is often said that there is nothing new under the sun. Even the Comprehensive Community Mental Health Center which symbolizes the "bold new approach" to the delivery of mental health services has been branded by some skeptics as the act of "pouring old wine into new bottles". To be sure, there is nothing terribly innovative--at least on the surface--about an out-patient mental health clinic, nor an in-patient ward for psychiatric patients, even in a community general hospital. Partial hospitalization programs and consultation to community care-givers are perhaps the newest, most revolutionary methods of delivering service to the community, but they, too, have had time to acquire a degree of sophistication through experimentation and experience.

What of the emergency service? Certainly the local general hospital has been in the emergency care business for many years. Procedures and personnel have been developed and adapted to accommodate a vast array of medical and surgical emergencies, and this has already, in many urban centers, been expanded to include the psychiatric emergency. Where the hospital has a psychiatric ward, or other security or holding facility, the emergency room usually serves as a screening or admissions office for such units. Such a psychiatric emergency service is not new in many communities--but neither is it at all adequate for a comprehensive community mental health program.

Inasmuch as many comprehensive centers are being established in the local general hospital, the possibility exists that the already functioning emergency room, along with the established procedures for admitting patients to an in-patient ward "after hours" may be permitted to suffice for the emergency service program.

The task assigned to this work group is to address itself to the crucial question:

"What should a truly comprehensive emergency service include?"

Group A is being asked to throw off the traces and constraints of traditional concepts and practices, and thereby to make its contribution to the conference at large one of imaginative, creative--even revolutionary--innovation.

In terms of what is known about the nature of acute psychotic episodes, suicide attempts, severe anxiety states, and the crises of everyday living,--

--what are the needs of the community for emergency service?

--how can these needs be most completely met?

--by whom should these needs be met?

--what community resources must be identified outside the center to meet the needs?

--what unique resources must be developed within the center?

--what are the boundaries of the "psychiatric emergency?" What kinds of problems fall within the scope of the center's responsibility for emergency service?

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* * * Chairman's Report * * *

Prepared and Presented By

Thomas S. Ray

The first issue which arose in the group discussion was concern over the use of the term "psychiatric" in the title of the group assignment. The concensus was that the group should focus on Emergency Mental Health Services rather than "psychiatric" services. This position seemed to be based on two main arguments:

a. The term "psychiatric" implies to some that the patients should be mentally ill, and

b. Professionals other than psychiatrists resent the implication that mental health services are necessarily "psychiatric" matters.

This quick expression of feeling solidified the group such that it did not lose a single member in its subsequent meetings.

The group had diverse representation but only one very egalitarian psychiatrist. Having asserted that the work belonged to all of them, not just psychiatrists, the participants became task oriented.

The group articulated several components of a comprehensive emergency mental health service which it thought were desirable. Although the ideas grew out of only two periods of discussion, the concensus of the group was high on most issues.

The group recognized that its work was toward an idealistic goal and that many centers would evolve less elaborate systems and perhaps implement the various components of emergency service in stages. However, a complete service should include the following eight programs:

1. 24-Hour Telephone Answering Service.

a. To be located adjacent to the emergency room in the general hospital.

b. To be manned by professionals, paid specially trained persons, and/or by trained volunteers.

c. To receive calls for help and to take appropriate action, for example:

1) Refer to other agency or key persons in the community.

2) Give appointments to appropriate elements of service in the Center on a priority basis.

3) Summon proper support personnel such as police.

4) Listen, allay anxiety, advise.

5) Follow up calls to see that individuals have found the help needed.

6) Attend mental health emergencies coming to the hospital emergency room.

d. Keep appropriate records on the nature of calls and the services rendered.

In regard to the matter of record keeping, there was considerable spirited discussion around the requirement of NIMH Biometrics Branch that classical psychiatric diagnoses be reported routinely for those considered to be patients of regular mental health facilities. This requirement, it was asserted, actually dictates the sequence of rendering services, often forcing into the process a costly and unnecessary step. It was hoped that an opportunity may be found in the emergency service to create a more appropriate system of recording which corresponds to human problems rather than to an outdated diagnostic system.

2. Referral Network.

A comprehensive emergency mental health service should establish, by prior selection and solicitation, a network of selected individuals who can respond to emergencies, or to whom emergencies can be referred. This is particularly important during "off hours", but it is also needed on a regular basis. These referral targets should include:

- a. Physicians
- b. Public Health Nurses
- c. Clergymen
- d. School Personnel
- e. Lawyers
- f. Law Enforcement Personnel
- g. Mental Health Professionals
- h. Volunteer "people-helpers" to be companions during periods of stress

3. Daytime Walk-in Service.

a. All receptionists everywhere in the center and in allied agencies should be trained to refer walk-in emergencies to appropriate elements of service.

b. Elements of service receiving such referrals should have a system for the rapid initiation of emergency services.

4. General Hospital Emergency Room.

Functions which should be included are:

a. Receive and attend to any physical emergencies.

*b. Listen to the patient and assess the precipitating human problem.

*c. Refer the patient to appropriate mental health services.

*d. Listen to and advise the family and friends who attend the patient.

*Several nurses in the discussion group felt that emergency room nurses could properly perform only the first of these functions. It was further felt that no center could economically provide the other three services on a 24-hour basis with professional personnel.

However, it was recognized that if the 24-hour telephone answering service were located in an interview room near the emergency room, the person on duty on the telephone could easily fulfill these latter functions.

Not only would a manpower economy be effected but the roles are complementary since both medical treatment for physical emergencies and psychological crisis intervention would most likely be required by the same individual patients over a period of time.

5. Mobile Emergency Unit.

a. The function of a mobile emergency unit would be to respond to calls for help which must be attended away from the center.

b. The composition of the unit would vary with the specific call. It might include provision for emergency physical treatment, crisis intervention, family mediation, etc.

c. Since part of this might be a routine police function, it would be necessary to coordinate the operation of the unit with the law enforcement agencies.

6. Research, Evaluation, Follow-up, and Individual Preventive Activities

a. A list of high risk individuals with hard-core problems should be compiled from case records.

b. Surveillance and/or follow-up of hard-core cases must be a routine procedure.

c. Experience tables reflecting the periodicity of problems and characterological data of high risk groups must be accumulated.

7. Community Education.

a. The emergency services offered should be extensively publicized in a proper manner for the general public and for key groups who come into contact with emergencies such as: Physicians, clergy, public health nurses, schools, police, etc.

b. Special information and educational programs should be provided for the same personnel as well as for the staffs of all relevant community agencies.

c. Special educational programs should be provided for special target groups composed of high risk persons such as Alcoholics Anonymous, Senior Citizens, Parents Without Partners, etc.

8. Emergency Service Supervision, Consultation, and Feed-back.

a. The program must provide for coordination, monitoring, and supervision of the components of the emergency service system to ensure that the parts are always functional, properly integrated, and to insure quality control of the service.

b. Provide for consultation and feed-back to cooperating agencies both to up-grade the system on a continuing basis and to ensure continuity of services to individuals seeking help.

(Editor's Note: Attention should be called to the fact that the 24-hour Telephone Answering Service, the Referral Network, the Research, the Evaluation, Follow-up, and Preventive Activities, and the Community

Education components cited as numbers 1, 2, 6, and 7 in the Report of Group A are already regularly being performed by most of the suicide prevention agencies in existence throughout the country. Specific examples worthy of note are the Emergency Mental Health Service in Atlanta, WE CARE, Inc. in Orlando, and LIFELINE in Miami. Here we have concrete evidence that Comprehensive Community Mental Health Center Emergency Services may readily implement the recommendations of this Workshop section by joining forces with already functioning crisis programs where they exist.)

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* * * Summary of Concerns in the Group * * *

Prepared By

Michael Glazer

A. The Manpower Problem

1. How can we facilitate the development of middle level or supportive personnel?
2. What type of training, and how much training should supportive personnel receive?
3. How much responsibility should such personnel be given?

B. Problems Raised by Bureaucracy

1. Must there be an enormous increase in paperwork to meet formal requirements of State and Federal Government?
2. Will coordination with other community agencies add to administrative problems?
3. How can the emergency service eliminate or minimize routine procedures in order to concentrate on the needs of the patient?

C. Support from Government, Especially State Government

1. How can local communities overcome perceived lack of appreciation and cooperation from state government?
2. Why are there so many barriers to the allocation of financial support from the states?
3. Why must political concerns take precedence over local community needs?

4. What can be done to facilitate understanding and enthusiasm from state personnel for local community goals and problems?

D. Community Role of Comprehensive Centers

1. How can a center avoid overlapping with other community agencies?

2. What are the means of obtaining cooperation and coordination between the center and existing agencies?

3. How can we ensure the best use of all resources within the community?

4. What is the best physical location for new centers?

    a. Must they be within and under the control of hospitals?

    b. Should they be separate and administratively independent?

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WORKSHOP GROUP "B"

THE OPERATION OF AN EMERGENCY PSYCHIATRIC SERVICE

Chairman: THEODORE MACHLER
Resource: FRANK S. PITTMAN

* * * Task Orienting Statement * * *

The development of an expanded service program to implement a changing concept of emergency care must, of necessity, involve a major investment of time and thoughtful planning in the problems of organizational structure and operational patterns. For the most part, general hospitals have developed and systemized emergency room procedures over the years until they are routine and mechanical for the sake of maximum efficiency. Changing an established system is a difficult as well as disturbing job.

Emergency room personnel are specially trained and oriented, not only in the methods of treating medical and surgical emergencies, but also as regards (a) the authorized channels of communication, (b) the chain of command, and (c) relations with other emergency elements of the community, such as the ambulance service, rescue squad, and law enforcement agencies.

Yet the advent of totally new concepts of emergency service for the community raises many potential problems of an administrative and organizational nature. It has been proposed that an adequate emergency program requires at least the following provisions: (a) a 24-hour walk-in service, (b) a 24-hour telephone service, (c) home visits, and (d) a service for suicide prevention.

Each of these activities falls beyond the scope of the usual emergency service presently existing in our communities. It is clearly, perhaps painfully, evident that the general hospital--where many comprehensive community mental health centers are being developed--must look beyond its own emergency service to other departments of the hospital, or to other agencies of the community, for help in providing adequate emergency mental health care.

With several agencies, or several units within an agency, being involved in an integrated program, certain administrative and operational problems may be anticipated--so what are they?

The task assigned to this work group is to come to grips with this problem and to present a realistic and insightful set of guidelines with which to approach the question:

> "_What are the administrative and organizational problems to be expected in the operation of a total emergency program?_"

Group B is being asked to endure the anxiety of ambiguity over the question of what services will constitute the total emergency program, and to think only of a very general operation involving a multi-problem, multi-agency network of services. Under such conditions,--

--what type of administration is required?

--is medical or psychiatric directorship necessary, or would available consultation suffice?

--how can both patients and personnel flow freely between various segments of the program?

--if external community agencies are a part of the network, what roles do their own administrative and clinical personnel play?

--who, and which segment of the program, has final responsibility for patients, and for emergency treatment decisions regarding both medical and non-medical problems?

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* * * Chairman's Report * * *

Prepared and Presented by

Theodore Machler and Frank S. Pittman, III

(The first part of this report was presented by Dr. Machler.)

The members of Group B began by trying to define certain terms. There was some difficulty defining "emergency services" in a way everyone could agree on. There were those in the group who felt that you were not really providing emergency services if you limited them to the emergency room or to the agency; that a true emergency service must embrace a larger concept. A true emergency service does not exist in time and space, but is mobile; it has a center of operation, but it goes to emergencies instead of waiting for emergencies to come to it. The group expressed more interest in practical examples of organization and administration than they did in trying to derive any general principles or axioms regarding administration and operation of emergency services.

We did not take the questions one at a time, and some may wonder how these questions were touched upon at all from the process, but they were touched upon. Dr. Pittman is going to discuss the process of our workshop in a few minutes.

The first question related to the type of administration which is required. It was felt that the administration should be first a concerned administration--concerned with the idea of doing something about emergencies. It should not be an administration which is directing emergency services because it is something which has to be done and therefore we must try to tolerate it.

The group made the assumption that in most low budget agencies you are not going to have administration and supervision separated, so individual or case oriented supervision and administration seems to have much value. We felt there should be an emphasis on finding alternatives of reaction; that the emergency service should avoid as much as possible having stereotyped lines of least resistance and reactions to emergencies, and should be constantly looking for new, alternative methods. This places a heavy responsibility on the administration to provide an atmosphere, and the challenge, where new alternatives can be explored.

There were some very strong feelings that supervision should be rather loose and non-perpetuating. That is, the emergency service worker should not have to feel that he is going to be subject to big brother type supervision; they should not become dependent upon the supervision to the point that they expect all of their decisions to be reviewed. There is such a transient nature to some mental health professions, and this unwholesome dependence upon supervision might be catastrophic if the supervisor moves on.

The group determined that the administration should perceive emergency service as an integral part of the total mental health program rather than an extra or expedient part. It is felt very strongly that the emergency service should provide prevention services in addition to intervention; that in addition to running around putting out fires, we might go around looking for combustible materials also.

The next question was, "Are psychiatric directors necessary, or would medical consultation suffice?" As to the necessity of psychiatric direction: unanimously, no! But there should be available medical consultation, and the availability is very important. It is not sufficient to contract with someone who may be available when someone needs him. Consultation should be more than just a cursory emergency response to the emergency team's emergency. It is better if the consultant is identified with the emergency service, and a part of the mental health center. It was felt that important in-service training opportunities are available if the consultation is frequent.

The third question asked how both patients and personnel might flow freely between various segments of the total center program. This stimulated a discussion of professional identity and the threats that exist when you utilize people with less than professional preparation. Very often the people who know better are threatened when their prerogatives are encroached upon. If the emergency workers get into the area of treatment, and the area of intake, there is very likely to be some professional fence guarding. Avoid the threats to existing services and prerogatives by proving that the emergency service does not detract but adds--it is complimentary to existing groups and services.

The fourth question was, "If external community agencies are a part of the emergency network, what role do their own administrative and clinical personnel play?" The external community agencies have the same problem of not inflicting your emergency service upon the community. The Comprehensive Center administrators must bear in mind that communities already have emergency services, and that there have been people providing such services for some time. They often respond in a resisting and negative way to your coming along with a new emergency service and the implication that nothing has been done previously. Maybe such services have not been adequate but they have existed in most communities. A good example that the group presented is the child protection services which have been functioning for some time, and have certain areas of expertise. They have established certain lines of communication and procedures that most emergency services will not have. For example, where do you put a child at night. The emergency service would be advised to call the protective services rather than attempt a decision--don't usurp another agency's function. The group did not see this as an overlap, but rather as the type of collaboration which avoids building up community resistance.

The fifth question was, "Who and which segment of the program has final responsibility for patients and emergency treatment decisions regarding both medical and non-medical problems?" The group entered into a spirited discussion regarding this. Dr. Pittman and I both felt that a very small percentage of emergency service decisions are medical decisions which require medical responsibility. There is a feeling, too, that there may be a tendency to read medical decisions into a lot of the emergency decisions that teams have to make. We feel that there is probably a larger percentage of legal problems than there are medical problems in emergency decisions, and the team should have access to legal consultation as well as medical and psychiatric consultation. There are two reasons for this: (1) it will keep you out of difficulty and make you feel better to know you are operating within the framework of the law; (2) also, it is quite helpful to the people you are dealing with to assist them within the framework of the law.

We came to the conclusion after a while that the most important organizational problem is to make the community aware of the need. There are several ways of doing this, but the idea is to precipitate, probe and shock the community conscience. The need exists; the awareness of the need is not always there.

The most important administrative problem, which was very clearly pointed out by the nurses in the group, is the transient nature of psychiatrists. Very often in emergency services, psychiatrists will get involved to a certain degree and then leave. An additional point was made that epidemiology is an important administrative function; you have a mass of data which should be used in some meaningful way rather than just for collecting statistics. Locate what the areas are in the community in which problems exist; what are the age groups; what are the economic problems that are precipitating emergencies. You often can find out which company in the community has lost its NASA contract from the number of referrals from that company.

(The second section of the report was prepared by Dr. Pittman.)

I have more of a comment than a report. I became aware of a lot of things through observing the process of the workshop group. I thought it really emphasized some points that Dr. Dublin made in his presentation last night and that we have heard throughout the three days. We started off our meeting by trying to define psychiatric emergencies. We found that some of the laymen in the group appeared to us experts to be very naive about psychiatric emergencies. So we immediately proceeded to squelch these people and not allow them to tell us any more about the unique situation in their own communities, which they were trying to ask a great many questions about.

This went on for about an hour and forty-five minutes, and when we reconvened in the afternoon, we found that our ranks were very much thinned, but we proceeded to ignore this. We went first into a monologue, then a dialogue, and finally a trialogue among the psychiatrists. The concern was how we were going to deal with, and circumvent, and influence the various community agencies and the community power structure. We even got to the point of discussing whether we could trust our public health nurses to go out by themselves on home visits.

Throughout all of this we noticed that people kept walking out of the room, and nobody else came in to replace them, until finally we were left with just a few psychiatrists, and a few silent nurses. One of the nurses finally managed to interrupt long enough to remind us that we charismatic and magnificent experts are very much like a carnival which comes to town, puts on a real good show and gets things pretty well stirred up, but then we fold our tents and sneak away into private practice, leaving the people who were there all the time with the same problems.

This analogy pointed up very much, and made us all very aware of how terribly important it is for the emergency service--and especially for us as administrators--to be part of the community that we are seeking to enter. The administration must learn to respect the fact that the problems have existed long before we sneaked out from behind our couches and discovered them; and furthermore, there have been people in the community dealing with these problems for years. We have to maintain respect for their position, and an understanding of their previous efforts. It is also well to remember the fact that probably long after we are gone, they will still be there struggling with these same problems.

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* * * Summary of Concerns in the Group * * *

Prepared By

Douglas Hindman

A. Planning for Services

1. How do we make the community aware of the need for emergency services?
2. Where and how can we expect requests for emergency help to appear?
3. What different types of emergencies can we expect?

B. Providing Services

1. What plans can we develop to respond effectively to a wide variety of emergencies?
2. How should we allocate staff, especially when there are limited funds?
3. How do we inform the public of the agency's services?

C. Running the Agency

1. What kinds of training and support can we provide for workers?
2. How do we assist the workers with specific legal, psychological, and medical problems that require immediate answers?
3. How do we keep professionals identified with the day-to-day workings of the agency?
4. How do we keep the agency operating as professional staff members move on to other settings?

D. Relations with Other Agencies

1. How do we keep other agencies and professional groups from feeling threatened by the emergency service?
2. How do we identify and utilize the special skills and resources of other agencies?
3. Can we avoid duplicating the efforts of other agencies which are helping the same persons? Should we even try to avoid overlap?

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WORKSHOP GROUP "C"

THE UTILIZATION OF NON-PROFESSIONAL PERSONNEL IN EMERGENCY TREATMENT PROGRAMS

Chairman: DANIEL G. BROWN
Resource: SAMUEL M. HEILIG

* * * Task Orienting Statement * * *

The utilization of non-professional personnel to perform a wide range of direct patient-care functions in the field of mental health is not as new as many people might believe. Its origin may be found during the years immediately following World War II.

For many years "the volunteer" was a kind of "psychiatric babysitter" whose duties usually included little more than representing the outside world to the institutionalized patient through the medium of canasta or bingo, a Christmas party, or a square dance. Beginning about 1960, however, a really "bold new approach" was instigated by Margaret Rioch and her colleagues who designed a plan to educate selected housewives in the art of psychotherapy--"non-traditionally trained counselors," they were called.

The success and feasibility of this source of mental health manpower can be seen in the proliferation of similar programs sparked directly by Rioch's daring experiment. The Los Angeles Suicide Prevention Center is one of many professional agencies to respond to the challenge of training the non-professional, with outstanding success.

Agencies such as the Salvation Army and the Save-a-Life-League in New York had begun pioneering the utilization of non-professional suicide prevention workers even prior to 1910. Programs such as FRIENDS in Miami, Rescue, Inc. in Boston, and the Samaritans in England have all been using non-professional people since their inception in the mid-1950's.

There are currently forty formal programs for suicide prevention in the United States, and at least nine more centers are in the planning stage. A recent survey of these agencies revealed that twenty-four operating programs and six on the drawing boards utilize non-professional crisis workers to answer the "cry for help".

But just as mental illness is responsible for only a small proportion of suicidal behavior, so too does suicide constitute only a fraction of all psychiatric emergencies. Suicide prevention is a necessary, but not sufficient program for the emergency service of comprehensive community mental health centers.

The task being assigned to this work group is to focus on the entire spectrum of psychiatric emergencies and grapple with the crucial question:

"What role can the trained non-professional play in the psychiatric emergency service of the comprehensive community mental health center?"

Group C is being asked to explore the manpower issue as it pertains to the delivery of emergency services. Since there is ample evidence that non-professional persons can be trained for useful therapeutic roles on in-patient wards and in out-patient clinics, and in suicide prevention programs,--

--what characteristics of the non-professional equip them to work with psychiatric emergencies?

--what limitations, if any, should be placed upon their roles in larger emergency programs?

--what skills developed for handling suicide crises can be used by non-professionals with other psychiatric emergencies?

--what problems must the non-professional overcome in order to find a place along side of professionals in the emergency service?

--which professional disciplines will find it most difficult to accept the non-professional? Why? How can the non-professional establish acceptance by each?

--are there various levels of non-professionals, i.e., high school graduates, junior college graduates, etc., which should be considered in staffing emergency services?

--how does a service evaluate the effectiveness of non-professional personnel? Are there any guidelines for performance criteria?

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* * * Chairman's Report * * *

Prepared and Presented by

Samuel M. Heilig and Daniel G. Brown

(The first part of this report was presented by Mr. Heilig.)

Our workshop discussions got off to a very enthusiastic beginning. We had the privilege of Dr. Dublin joining the group, and in his own spirited way, he enjoined us to make maximum utilization of these people we have been variously referring to as volunteers, non-professionals, or supportive personnel. The essence of his comments was that the mental health professionals have, by and large, neglected the field of suicide prevention. He also suggested in a strong way that we should be more liberal and imaginative in selecting and utilizing people who want to help others. Dr. Dublin was concerned (and I think correctly) with our tendency to "over-professionalize" these people. He suggested that people with good common sense, friendliness and warmth are able to do a great deal of good.

There was some feeling in the group's response to Dr. Dublin that possibly not all people are suited for this kind of work. Among the points raised in this regard were the criteria for selecting these workers. For example, they should not be judgmental of human behavior, nor should they manifest low threshholds of anxiety, nor have a tendency to be easily depressed.

Also in our group was Mrs. Rosemary Jones, who is director of the Lifeline program in Miami. She reported on some of her experiences with volunteers in that program. When people don't seem suited to the task of direct clinical work on the telephone, she finds other tasks for them; they try always to use people who offer their help in some way. There was some discussion, without resolution or conclusion, about the problem of the "do-gooders" and how they can be utilized, if at all.

There was also some discussion about the feeling that professionals tend to be "de-humanized" or to lack warmth. I take personal umbrage with this; I don't agree with it.

The group tried to distinguish, or to clarify the distinction, between a suicide prevention service and a crisis service in the broader sense. We also touched on the issue, which has been commented on in other groups, of where a crisis unit might best be situated; whether it should be located in the Emergency Room of the hospital, or in the Comprehensive Community Mental Health Center, or separate from the Center.

The question was raised of how to part company with, or fire, a volunteer who proves to be unsuited for the work. There were no good suggestions on how to do this, and I think we must recognize that it is always a difficult task.

The last issue we focused on is an interesting point. There are several precedents for the utilization of personnel who are not specifically trained but nevertheless perform fairly sophisticated tasks. The military services, for example, have a long history of training their own people to do complex, specialized tasks; an obvious example is the medical aide. One of the reasons that this has not been practiced so extensively in civilian areas revolves around the matter of legal implications in non-professionals doing work which approximates a professional task. This led to a discussion of the whole question of legal implications in using non-professional persons.

I should add that we had some discussion, not entirely related to the use of non-professionals, regarding the experiences encountered in organizing a crisis service. One of the suggested organizational steps was to procure the literature available from the Los Angeles Suicide Prevention Center. This was encouraged as a beginning step. Also the film "Cry for Help" provides an excellent resource. Finally, there was some discussion on how one might organize the lay advisory board to represent a broad range of the community.

(The second part of this report was presented by Dr. Brown.)

I would like to make a few comments relative to the use of mental health workers, or assistants, in addition to the volunteers. We are now developing (and I think this is of considerable import) a new generation of mental health assistants, workers or associates. Dr. McPheeters' term "middle level workers" is probably as appropriate a term as any we can use for them. By the term "middle level" we are designating a group of individuals falling between the fully trained professional and the untrained attendant level personnel. This is a very recent development. The Associate of Arts level mental health person, or two-year junior college graduate, has yet to be graduated, but a year from now we will have the first graduates in the country coming from a program at Purdue University, Ft. Wayne campus. There are approximately 25 individuals who will earn an Associate of Arts degree in Mental Health Technology.

The Southern Regional Education Board has pioneered in furthering this development by having called a conference to bring together junior college executives and mental health professionals to consider this major development. This was followed up last April by a smaller meeting in Atlanta of a group of junior college individuals and mental health professionals beginning programs this year. In the process of calling this meeting, we discovered that these programs are developing all over the country. We know definitely that similar programs are beginning this month: in Florida, at Daytona Beach and Miami; and in Alabama, Illinois, Ohio, Indiana, Maryland, New Mexico and Colorado. I am simply calling attention to the fact that this is a major development in the mental health manpower area, and it will have implications that will be felt in the mental health programs all over the country.

The question we might pose, and consider at this point, is, "What are we doing in our existing mental health programs to prepare for the utilization of a new source of mental health manpower--or mind-power, as Dean Mase termed it? These people are in the making; help is coming! Yet, there are resistances to this development; there are problems! For example, one of the problems (about which there seems to be no disagreement) is that probably the last groups to accept these people are the national professional associations that represent the professional interests of the established disciplines. At any rate, as of now, the professional organizations have done very little. The stimulation for the development of these middle level people has come from interested and concerned individuals and groups, at the regional, and state, and at the local level.

In addition to the Associate of Arts programs, there are also new programs at the Bachelor's and at the Master's levels to develop these middle level workers. In Georgia for the past year and a half, college graduates, with Bachelor's degrees in one of the behavioral sciences, have been used at the Georgia Mental Health Institute in full time mental health work. My understanding is that the overall program has been well received. There is in addition at least two programs we know about at the Master's level. One is at Northern Illinois University, which has a new Master's degree in Mental Health; the first class will be graduating this year.

These are further examples of developments that are going on now which I think have far-reaching implications for the problem of mental health manpower and so-called non-professional sources of assistance. I believe the planning of emergency services in our communities must include a cognizance of these developments, and provisions must be made to insure the proper and full utilization of these newly trained middle level people.

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* * * Summary of Concerns in the Group * * *

Prepared By

Richard M. Drag

A. Identifying the best volunteer candidates

1. Is everyone suited for the activities associated with crisis work?
2. Are there particular kinds of people who are most suited?
3. Can certain desirable characteristics, i.e., "desire to be helpful," be overdone and have a negative effect?
4. Are there particular kinds of people who are specifically unsuited for crisis work?
5. Do anxiety and tendency toward depression disqualify a volunteer, or are these traits "normal" if not present in pathological degrees?
6. Does previous experience in psychotherapy help a person function as a volunteer in crisis work?
7. What is meant by the term "common sense" which is often a requirement for volunteers?

8. Are the desired characteristics for volunteers specific to each program or center, or are there some universal characteristics to be expected in applicants?

9. Are psychological tests useful, and should they be given, to select volunteers?

10. Is careful interviewing as good, or better than psychological testing?

B. Are volunteer crisis workers "do-gooders"?

1. Is being a "do-gooder" a good or a bad trait? What is meant by the term?

2. Is a "do-gooder" one who seeks to satisfy his own needs at the expense of the patient?

3. Are "do-gooders" ever helpful in certain kinds of cases?

4. Can the term "do-gooder" refer to persons with altruistic interests and needs?

C. What happens after a volunteer has been accepted?

1. How can volunteers be "fired" if they don't work out?

2. Should applicants who can't function well in patient contact be given other tasks to perform in the program?

3. Should all volunteers be accepted into the program on a "trial" or probationary basis?

D. Roles of volunteers and professionals in broader areas of crisis intervention

1. Can volunteers be given responsibility for helping in family problems, or personal "problems of living" which may not yet involve suicidal thoughts?

2. Should a "suicide prevention" program be distinguished from a "crisis intervention service"?

3. What is the distinction between "mental health crises" and "problems in living"?

4. Should psychiatrists be relied upon to handle or direct the handling of all "problems of living" as well as "mental health crises"?

5. Are there other areas within the Comprehensive Community Mental Health Center where the volunteer can be utilized?

E. Roles of volunteers outside the Comprehensive Center

1. Can, and should, the volunteer reach out physically into the community to meet with persons in stress?

2. Can a corps of indigenous volunteers be recruited to remain on call in certain local neighborhoods?

3. How far should the emergency service go in providing relief of crises? Is location and identification, followed by referral to other agencies, sufficient?

4. What are the kinds of problems which automatically demand another resource, such as the law enforcement officer?

5. How can volunteers realize the importance, and learn the skills, of maintaining relationships which are mutually valuable with other agencies?

6. What are some of the ways in which the volunteer emergency service can assist, as well as be assisted by, other agencies in the community?

F. What utilization can be expected from middle level persons who are neither professionals nor volunteers?

1. How will such middle level persons affect the mental health movement?

2. Who assumes responsibility for the middle level worker if they replace unavailable professionals on the paid staff of agencies?

3. How can the middle level worker be protected from the usual jealous "fence-guarding" in which professional disciplines engage?

4. What are the legal problems and implications of employing middle level personnel, and how should they be handled?

G. How does one get an emergency service started in a community?

1. Where do you get relevant literature, training materials, and other guidelines?

2. How do you form an administrative or governing board to run the program?

3. Who are the most important people to have involved in the establishment of a volunteer crisis intervention service?

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WORKSHOP GROUP "D"

THE DEVELOPMENT OF SUICIDE AND CRISIS INTERVENTION SERVICES

Chairman: CHARLES EDWARDS
Resource: EDWIN S. SHNEIDMAN

* * * Task Orienting Statement * * *

The first suicide activities were developed in this country before 1910. But it was in the mid-1950's before "the movement" finally caught hold. Today there are over forty suicide prevention programs in operation, and 6 to 10 more which are planning to initiate services, probably during 1967.

There are many different models of organization represented among the existing agencies. Seventeen of them use only professionally trained mental health specialists working out of state hospitals, community clinics, public health departments or medical schools. In Portland, Oregon these professionals are actually "volunteers" who take duty on their own time.

The majority of programs use the trained non-professional to answer the phone and administer crisis therapy until the case is transferred to another resource. Almost all the non-professionals work as volunteers in the program, but in Atlanta they are paid an attractive salary for 40-hour per week employment.

In some communities the volunteers work out of their own homes on a rather informal and independent basis, whereas in others the center maintains an office, a complex communication system, and facilities for face-to-face crisis counseling.

Indeed, there are many models of operation, and none has been demonstrated to be superior to the others.

About half of the existing suicide prevention centers were developed primarily through the auspices of the local chapter of the Mental Health Association. Their financial support comes from United Funds, MHA budgets, or private contributions. A few centers with research strength have been able to secure Federal Demonstration Grants to supplement their fiscal resources.

The States have thus far done almost nothing to either promote or support the development of programs for the prevention of death by the nation's "number 10 killer". The motivation and the enthusiasm for this rapidly spreading field of suicide prevention have come almost exclusively from the spirit of the local citizenry.

In 1963 Louis Dublin predicted that "the development of a strong interest in suicide prevention may be an excellent first step into the larger field of sound mental health. . ." It has also been proposed frequently that a suicide prevention program "can demonstrate the principles of modern action for mental health, and thus initiate the development of a comprehensive community mental health program."

Experience has shown that suicide prevention programs can be established in a relatively short time, and with a minimum of financial support. It is also apparent that such programs quickly become general crisis intervention services, receiving cries for help in a wide variety of problems.

The task assigned to this work group is to address itself to the important question:

> "How can Suicide Prevention Centers make their most significant contribution to the total mental health program?"

Group D is being asked to develop a position, or a set of attitudes, regarding the establishment of suicide prevention programs in this country. Much is already known about suicide prevention, but many communities still have a number of important concerns. What principles can be set down for the establishment of suicide prevention programs?:

--Should the State Mental Health Departments assist the establishment of suicide centers?

--What role should local city and county government play in the development and support of suicide programs?

--What role can suicide programs play in the promotion of community mental health centers?

--Should communities set up a suicide program now, or wait until a comprehensive center is established in the area?

--How can new suicide prevention programs learn from existing centers? What are the most important questions to be solved to get a suicide center established?

--Are there any guidelines which suggest specific organizational and clinical procedures for new suicide centers?

--How can a community assess its needs in order to plan an appropriate program to meet them?

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* * * Chairman's Report * * *

Prepared and Presented By

Charles Edwards

One could hardly classify our Workshop Group as a "group"; it seemed to be more like a demonstration of the very problem that we are attempting to solve in some areas of mental health. Let me tell you how this group was loaded, and then you will understand what I mean. I won't give names of the participants, I just want to give you some concept of the titles: Chief, Assistant Professor, Director, Psychiatrist Director, Volunteer from Mental Health Association, Chief Clinical Psychologist, Psychiatric Social Worker, State Department of Mental Health Consultant, another of the same, one Social Worker from a suicide prevention oriented emergency program, another Consultant to a State Health Department, Chief Psychiatrist, Executive Director, Guidance Director, Social Worker, Doctoral Student, one so-called non-professional volunteer from a suicide prevention center, a Director of Psychological Services, a Psychologist, and another Director. So in this group we had one person from a place called a suicide prevention center, and another person who works in an emergency mental health program; the rest were all chiefs. With this composition, it seems we were "forced" to retreat to our traditional stances.

The topic for our discussion was, "How can a suicide prevention center make the most significant contribution to the total mental health program?" The best conclusion I can draw from the attitudes expressed by the group members is that it is a toss-up between "battleground" and "scapegoat". At least one of these roles seemed to be ascribed to the suicide prevention center most of the time. Of course, our representation was such that we did not learn very much about suicide prevention centers, but the answers to task questions were handled rather quickly.

One of the first questions we tried to solve was, "Does anybody feel that we should really try to define suicide prevention, crisis intervention and emergency mental health?" Nobody particularly wanted to deal with that issue, so we didn't.

Another question was, "Should the mental health departments assist in the establishment of suicide centers?" This started an immediate power struggle by all the people from state departments of mental health. Those from the local level responded with an insistance that they should either assist or desist. I will come back to some of the feelings that went with these questions in a few minutes.

"What role should the local city and county government play in the development and support of suicide programs?" It was generally agreed that support should come from the local community; that the community should take a benign but active interest in suicide prevention, but not be controlling.

"What role can a suicide program play in the promotion of community mental health centers?" Here is where the scapegoat role was assigned by those who seemed to have a need to blame the suicide center for many of the ills in community mental health programs. Others, on the other hand, felt that suicide programs within a community tend to act as a kind of stimulus toward mental health activity, incorporating what has been thought about as "helping people", even though they may be excluded from the mental health establishment.

"Should communities set up suicide programs now, or wait until the comprehensive centers are established in the area?" That was answered in this sort of fashion: "If you have a good reason to wait, wait; but if you don't, then start." This is over-simplified; the concensus was start! From that point on we were in trouble, because we didn't know who was supposed to start.

There were some guidelines coming out of our group discussion. It was felt that suicide centers should be established at the local level. They should attempt to integrate themselves within the existing health establishment of the local community, and hopefully to work within the reality of the local political power structure; not to do either of these two things is tantamount to failure. I think no program can succeed very long or very effectively if it ignores these things--the existing health establishment, and the reality of the political power structure.

The question of defining under which auspices the center should develop, whether it should be part of an upcoming center or be started independently, was resolved by the suggestion that you go ahead and start a program but aim toward integration with the comprehensive community mental health services in an attempt to augment this service as well as augmenting and complimenting other helping agencies and services within the community. It should tend to serve as a catalytic agent in bringing these helping agencies and people together.

One of the major reality problems is that of funding. We had no answer to this. But the area of publicity proved to be an interesting subject. Dr. Shneidman advised the group that a center must keep a hand on the rheostat in order to control publicity. He saw this as being rather important to the future of any center. I would certainly agree with that from our experience in Atlanta. You can do yourself irreparable damage by poor handling of the necessary public relations. Advertisement is necessary to reach the people, but it certainly should be controlled by those with the most knowledge about the possibly deleterious effects.

I would like to comment on a few of the things that really happened in the meeting. As a sort of opening gambit, this diverse, professionalized population made a plea for structure and coordination. As most group therapists would tell you, that was the theme of the meeting right there. Again, there was no ability to recognize the terminology of crisis intervention, emergency mental health, and suicide prevention. Dr. Shneidman sort of provocatively started somewhere along the line: "Why don't you just go ahead and start services? Someone open a door, and see what walks in; and then you build from there." This started a great concern over the matter of "coordination control". The battle lines seemed to be drawn at that point.

In the second session the State people emerged as leaders of the group. They made strong pleas for State supervision. They were very concerned about the small, somewhat autonomous programs springing up hither and yon, and were making a plea for coordination, along with a somewhat angry demand for insuring both the quality of service and the competency of people working in these programs. The rationale seemed to be that the State in all instances has the legal responsibility for maintaining these services. This tended to set this group against the other smaller group, who very strongly felt there should be local autonomous programs which are free of the bureaucratic control. This power struggle continued throughout the session with the State agency people aligned against the autonomous local program concept.

It was interesting to observe that we had within this particular group a sort of microcosm of the kinds of organizations that I visit frequently as director of mental health planning in Atlanta. I had the feeling that I had been in this meeting before. Here we were represented on a local, state and federal level: administrators, the full spectrum of the professional mental health disciplines, and a para-professional person or two. Yet, the group's very inability to deal effectively with its task demonstrated a general phenomenon which you can extrapolate into any community or any state level or federal level. When you get all of these same roles played and try to sit them all down together, you get the same results--power struggles, with a great deal of anger and hostility.

The volunteers made a plea for local involvement, and the State immediately began demanding control of coordination and regulation of these programs. Then the federal government, represented by Dr. Shneidman, appeared to assume the role of a seldom-visiting, benevolent grandmother who comes in and says to the grandchildren (or the local people), "act out". But the (parental) State is saying, "Damn it, you only come around now and then; then you go away and leave all these organizations all over the State and we have legal responsibility for them." The local people were simply out-gunned, and they withdrew. The non-administrative professionals attempted to be peacemakers, and they agreed and disagreed with everybody in some disarray.

It seemed evident that we discussed as well as exhibited the impasses present in any mental health planning organization that I have ever seen. I would be willing to bet it's true in your community as well. Traditional roles were assumed and defended; everyone became threatened, angry and defensive; the usual frustration and disgust was accomplished; the group agreed to disband early and had no desire to come back together this morning.

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* * * Summary of Concerns in the Group * * *

Prepared By

Richard Truchses

A. What are the goals or purposes of a suicide prevention program, and how can the program be evaluated?

  1. How effective has the Los Angeles Suicide Prevention Center actually been?

  2. Does the suicide rate decline if a prevention program is effective?

  3. Is "preventing suicide" the goal, or are we really trying to help people resolve crises more productively?

  4. What are the targets of a suicide prevention service? Are there "target groups", or "target individuals", or both?

  5. What effects can be noted in a community when a suicide prevention center opens?

  6. Do suicide prevention programs really do any good anyway?

B. Suicide Prevention, Crisis Intervention, and Emergency Mental Health Service.

  1. Is it appropriate to define each type of service, or are they all different names for the same thing?

  2. What are the needs of the community for each type of service? How can community need be assessed?

  3. What is the appropriate treatment, or the most effective process for meeting needs in these areas?

C. What experiences have been gained thus far in the organization of suicide prevention programs?

  1. What difficulties can be expected to arise in new agencies?

  2. Does it matter whether or not you follow specific procedures, i.e., holding personal interviews with callers?

  3. Does it make a difference what name you give to the service?

  4. How should suicide prevention centers be structured? and coordinated?

5. Should suicide prevention programs be developed by special agencies, or can every agency in the community provide suicide prevention service?

D. Control by State Mental Health Authorities

1. How much should local people be responsible for developing and operating an emergency service?

2. Should local suicide programs be coordinated at the state level? Why? How?

3. Should the state authority have any role in suicide prevention programs?

4. What role should the state play? What role should NIMH play?

5. What is meant by "local responsibility" for suicide programs?

6. Can local groups, without state control, adequately insure quality control in matters of professional supervision, training, selecting manpower, and maintaining competency?

7. Can, and should, the state coordinate local suicide programs without supplying the money to start and operate them?

8. Can the state authority provide funds for local suicide prevention programs?

E. How do you start a suicide prevention program in the community?

1. Are there specific guidelines for starting centers?

2. How much publicity should a center have? What kind of publicity is effective and appropriate?

3. How can a center maintain control of its publicity?

4. Are there any guidelines for training personnel at all levels?

5. How do you keep the morale of the workers? What problems upset morale?

6. Are training materials available? Where can they be ordered? How much?

F. Involvement of suicide prevention programs with larger community concerns.

1. To what degree has the Los Angeles Suicide Prevention Center been able to integrate itself into the community?

2. How can one assess the need of the community for what the suicide prevention program can offer?

3. Can the suicide prevention service handle the legal issues of invasion of privacy, forced entry into the scene of a suicide attempt, revelation of "confidential" information, etc.?

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WORKSHOP GROUP "E"

THE INTEGRATION OF EXISTING SUICIDE AND CRISIS PROGRAMS WITH COMPREHENSIVE MENTAL HEALTH CENTERS

Chairman: E. ARTHUR LARSON
Resource: RICHARD K. McGEE

* * * Task Orienting Statement * * *

During the past 10 years one of the most significant developments in the field of mental health has been the proliferation of programs for suicide prevention in many communities across the nation. As early as 1933 Louis Dublin began promoting the establishment of suicide prevention agencies, but it was not until the mid-1950's that something promising began to happen. With the establishment of the Suicide Prevention Center in Los Angeles the Federal government, through an NIMH demonstration grant, took what was to become the first step in a national campaign against the tenth leading cause of death.

In recent years the growth of suicide prevention activities has been truly phenomenal. In the Southeast the story begins in 1959 with the establishment of FRIENDS in Miami, Florida. Later, an emergency mental health service was established in the Pinellas County Health Department in St. Petersburg. In 1965 suicide prevention centers began operating in Orlando and Chattanooga; they were followed in 1966 by centers in Cocoa, Florida, and Atlanta, and in 1967 by a second program in Miami. Currently suicide prevention services are being organized in Tampa, Jacksonville, Nashville, Knoxville, Columbus, Charleston, and Greenville. This makes a total of fourteen potential suicide prevention agencies in four states of Tennessee, Georgia, South Carolina, and Florida.

Now, our communities are forming comprehensive mental health centers--construction and/or staffing grants have already been approved in thirty-three Southeastern cities. Six of these communities presently have both a comprehensive mental health center grant and a suicide prevention program. Seven cities have a suicide prevention program but no comprehensive mental health center as yet. It may be expected that several more cities will soon have both types of services.

The task being assigned to this work group is to deal with the general topic of:

> "How can established Suicide Prevention Programs play a useful role as an integral component of the Comprehensive Center's emergency service unit?"

Group E is being asked to work out a set of principles or guidelines aimed at avoiding both the waste of competing or duplicating services, and the frustration of seeing a useful agency, developed by hard working, dedicated citizens, being dissolved or abandoned. The suicide programs in the Southeast have developed corps of skilled crisis workers, whose dedication to a community health problem represents too valuable an asset to be thrown away in any community. Therefore,--

--should the suicide centers move physically and administratively into the comprehensive mental health center, or should they remain separated?

--what are the factors which determine whether or not an existing suicide program should integrate with the mental health center?

--what might be expected to happen if the comprehensive centers developed their own suicide services and they and the established program proceeded to ignore one another?

--is it even possible for local service agencies, organized by non-professional personnel, to find a place in the massive administrative structure of State, Regional and Federal bureaus which direct comprehensive center funding?

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* * * Chairman's Report * * *

Prepared and Presented by

E. Arthur Larson and David A. MacDonald

(The first part of this report was presented by Mr. MacDonald.)

The topic we were exploring was the integration of existing suicide and crisis programs with Comprehensive Community Mental Health Centers. The funding and eventual emergence of Comprehensive Community Mental Health Centers with a blueprinted program for the provision of emergency care has raised the question in many communities as to the fate of existing emergency care centers--whether they are focalized around suicide prevention or the broader problems of crisis intervention in general. Questions of whether these existing centers should continue as autonomous units or should be absorbed by the new agency, and many other alternatives, were prime considerations. In attempting to discuss this issue as a group, we soon found that communication initially was quite difficult due to the wide range of responsibilities represented by the group members. In addition to this, the characteristics of the crisis centers represented by these people also made communication difficult, especially such characteristics as the kind of service offered, the professional-volunteer ratio at the center, the political power structure of the community served, the unique history of the agency, and quite importantly, the impact of the personality of the director or directors as they determine policy and extent of service. Each of these factors in turn were seen to dramatically affect the ways in which the particular agency would most appropriately relate to the coming Comprehensive Community Mental Health Centers.

One of the prime problems to which the group addressed itself was the potential impact of the physical and administrative merger of these agencies in the future. One opinion heard quite strongly was that integration of agencies could lead to greater power, effectiveness, efficiency and service to the community. This syllogism was viewed by several in the group to be somewhat of a non sequitur; they had observed quite often that the increase in an organization often led to an increase in red tape and territoriality, and a decrease in effectiveness of patient service. For those representing existing crisis intervention agencies, the scary feeling was expressed that integration with the coming comprehensive center would bring a great loss of freedom, especially where an emergency service would be required to refer cases to the new parent agency, rather than to the most appropriate care agency in the community. With present autonomy and freedom, agencies often can cut through red tape and formality due to their pressure group status as an emergency agency, thereby delivering care to a person in need at the time of need, not a day or a week later. Phenomenologically, the threat of loss of freedom and autonomy was experienced by existing agencies as being "swallowed ". This came out quite often. Not only would there possibly be physical and administrative batteries and structures to be contended with, but also the very motivation which sparked the emergence of these emergency programs could be lost--motivation based on love and concern for persons rather than the salary and positions of status, or the technology of professional specialties.

Another feeling expressed was the anxiety over, and the consequent distortion in understanding of, on the one side, the role of the volunteer, and on the other side, of the role of the professional in crisis intervention. For the volunteer, the oft-found conception of the professional was that he tends toward being a cold, distant and rigid authoritarian, which has been alluded to by other Group Reports. To work under such persons seems to many to be quite deadly. For the professional, on the other hand, his distortion of the volunteer role image carried with it the vision of the altruistic den-mother who is bound to become hysterical when distressed.

Once members had really looked at these feelings, they were able then to move into, I think, really open trust and communication. I think this may be unique from listening to some of the other groups. A strong agreement was seen that some kind of continuation of this openness in work group sessions needed to be maintained, especially in a person-to-person interaction, rather than professional title-to-title, or title-to-volunteer relationship.

As the group attempted to home in on some of the practical guidelines for the coordination of emergency or crisis intervention services, they found that several necessary and sufficient conditions for an intervention service needed to be met by the terms of any integration, or coordination move. They may be stated thusly: If (1) twenty-four hour phone service, (2) home visits, (3) follow-through assistance could be provided and emergency care could continue as (4) flexible, (5) person-oriented and (6) non-stereotyped in approach, then some kind of coordination of emergency care services could be effected. If any of these conditions could not be met as a result of this coordination, then the existing crisis intervention agency should remain autonomous and independent until such conditions could be met in its affiliation with the comprehensive center.

The medical-legal problems associated with the coordination and setting up of emergency centers were agreed by all to be completely nebulous and unclear; there is a great need here for some sort of guideline to clarify what the parameters can be for these agencies.

Finally, it was agreed that each community must work out the best possible individual plan for its emergency service. This plan should be based upon the unique history of the agency, the community power structure, the people who are involved in the particular program, whether this be volunteer-oriented or a professional agency. It appears, however, that even if the conditions I mentioned before were ably met in the most ideal situation, it might be best for suicide prevention centers to function as coordinated yet autonomous agencies in the role of dispatch and referral. This seemed to be the feeling expressed by many of the people in the group.

It was finally proposed that a valuable means for facilitating an integration or coordination would be through the medium of an unstructured retreat, where persons from both agencies could meet on an informal basis to assess each other's future role in emergency care service to the community. Again, this would provide a person-to-person level of interaction rather than a title-to-title or professional-to-volunteer level. Furthermore, the valuable role of the volunteer in emergency crisis intervention work could be expanded and utilized more effectively once the myths regarding their effectiveness or ineffectiveness were broken down in this interaction.

(The second part of this reported was presented by Dr. Larson.)

I would just like to mention what I think is one of the essential features that I am able to take back from the total meeting, and particularly from our group. This group was composed of people not unlike that of Group D. We had people from all specialties--psychiatry, psychology, volunteers, clergy, social workers, psychiatric nursing. They were of varying statuses: some were representing community mental health centers, some represented suicide prevention or crisis intervention programs; some were from established programs, some from programs in organization. So we also had the complexity of Group D. We also adjourned early, but I think for different reasons.

The difference, perhaps, between Group E and Group D was that although Group E also stopped early in their discussion, one had the feeling that they would like to get back together again, despite the full range of titles and status represented. I think this is one of the essential features that has to be looked at when you talk about how you can effectively integrate established suicide prevention programs with the new developing concept of Comprehensive Community Mental Health Centers. I know it has been said over and over again--cooperation and coordination. You can talk those words, but unless you experience those words there is no real cooperation or coordination. I think one of the things which allowed Group E to actually approach a moment of true cooperating and coordinating was that we openly faced the issues, and we were willing to stick together as we discussed them; that is, these blockades that would interfere with a volunteer getting along with a psychiatrist or a psychiatrist getting along with a psychologist. I would hope many people now can go back to their home communities and actually face these same issues--if you keep avoiding them there won't be any real cooperation. This is why we came up with the thought that perhaps what is needed at this moment, rather than regulations, would be something like a retreat where you and your local group can actually get away from the office and try to discuss the various basic issues involved in the coordinating of these services.

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* * * Summary of Concerns in the Group * * *

Prepared By

David A. MacDonald

A. Present Operation of Emergency Care Services

1. When a call for help is received by a center, how is it responded to initially?

2. What are some of the follow-up processes employed in helping the caller?

3. What roles do volunteers presently play in a service, and how have they worked out in these roles?

4. Have the professionals in an agency clarified their own feelings about volunteers?

5. How are present centers perceived by the community at large? Are their functions perceived accurately or inaccurately by most persons?

6. What are some of the medical-legal implications in answering emergency calls when the caller suicides, or the worker is injured in the process of extending care? What kinds of protection do workers now have in making home visits?

7. What sorts of problems have agencies encountered with "repeaters"?

8. How do you deal with persons who skip from agency to agency without committing themselves to any treatment plan?

B. Barriers to Integration of Emergency Services

1. What kinds of problems can be anticipated in physical and/or administrative integration of emergency care centers?

2. What would happen to the role of the volunteer if an existing volunteer based agency is joined with a paid-professional staffed agency?

3. Will inter-agency jealousy and territoriality become barriers to integration of services?

4. Is the problem of personality clash between directors of care agencies likely to be a block to coordination of existing agencies?

5. Could it be that a conflict in motives exists between volunteer-staffed agencies (love, concern to help) and paid-staffed agencies (money, status)?

6. Will the integration of staffs tend to reduce, or intensify, these conflicts of motives?

7. Doesn't the problem of relationships between professional and volunteer workers stem from the professional's own anxiety and feeling of role diffusion, as well as the volunteer's perception of the professional as cold and distant?

8. What methods might be utilized to reduce conflicts between professional staff and volunteers? Would a retreat be a possible solution?

C. Consequences of Integrating Services

1. Will the present problem of red tape in bringing about swift patient-care become more intensified as an agency becomes more federally controlled?

2. Even when there is the best of coordination between agencies in an integrated center, does the loss of diversity or separate identity often undercut the quality of patient care available?

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WORKSHOP GROUP "F"

COORDINATION OF EMERGENCY SERVICES IN MULTI-CENTER AREAS

Chairman: LEONARD LINDEN
Resource: ANSON HAUGHTON

* * * Task Orienting Statement * * *

The Comprehensive Community Mental Health Center is not just a building or an agency--it is a concept. It is a concept which puts many of our traditional and habitual ideas to the tests of practicality and efficiency. The concept of comprehensive mental health care is that of an umbrella spreading across a community offering an integrated system of varied services to whomever is in need, wherever, and whenever the need occurs. As we have been told many times now, the word "center" really means "program," and not a building housing multiple services all under one roof.

The "comprehensive center" concept brings with it a second concept which is also being re-defined in ways which should challenge our complacency. This second concept is that of the "community".

What is the "community" with which we are concerned in establishing a comprehensive center? This, of course, has been defined by the State Plan which is approved each year. In Florida, for example, there are two extremes represented: one "community" in the rural north central area actually includes 10 counties, each its own central (County Seat) community, with a combined population of 219,200, and an area covering over 6,000 square miles. The other extreme is found in the Miami area which has a population of 1.4 million people and an area of 2,000 square miles to be served by seven "community" mental health centers. All the States in the Region have similar rural areas and metropolitan centers.

This situation presents a significant problem for the planning and operation of emergency services. Since each comprehensive center must provide emergency services for its area, what happens when the "community" of the center area does not parallel the community as the citizen in crisis knows it?

Does it seem feasible or practical to have seven or eight 24-hour emergency telephone numbers to call in Miami or Atlanta, or even three emergency numbers to choose from in St. Petersburg or Memphis? What kind of organization is represented by having to call one emergency number for acute psychotic reactions, another for suicide prevention, or another for alcoholics anonymous, and still another for help with a severe crisis in the problems of daily living?

The task assigned to Group F is to undertake a careful consideration of the multi-center communities and to pose some suggestions to answer the question:

"How can emergency services be coordinated throughout a community which has more than one comprehensive mental health center?"

Group F is not being forced to accept the coordination of emergency services as an a priori "must". Rather, the group might begin by exploring whether or not a coordinating mechanism is desirable and why. Then, if some centralized emergency telephone service is found to be desirable--

--are there certain agencies within a city where a centralized emergency telephone should be located?

--is it possible that the suicide prevention center might provide this function in multi-center cities?

--what kind of personnel should answer the centralized emergency telephone?

--are there other methods for communicating emergencies which should be established for those social or ethnic groups for whom the telephone is not a frequently used tool for communication?

--what functions might be assigned to the central answering service?

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* * * Chairman's Report * * *

Prepared and Presented by

Leonard Linden and Anson B. Haughton

(The first part of this report was presented by Dr. Linden.)

Our group was faced with the task of exploring how emergency services might be coordinated throughout a community in which there is more than one Comprehensive Community Mental Health Center. We were not forced to a priori accept the necessity of coordination of emergency service, but it was interesting to note that, to roughly quote one of our members, ". . . like motherhood, the value of coordination is unquestioned." However, it was recognized that coordination is very difficult, just as it is difficult to be a good mother. There was the recognition on the part of all members that coordination produces a gain to the participating agencies. Yet, coordination also involves relinquishing certain individual agency, or center, prerogatives; there was no question that relinquishment of prerogatives is the cost of the gains. The question was, are the gains sufficient to cause this relinquishment to be considered by the members.

The group found it impossible, as might be expected, to arrive at a definition of what constitutes a community; rather, we were faced with the recognition that the community must be operationally defined in each case.

As to where a centralized emergency telephone service should be located, the police station was one of the major places ruled out. This was not because of any perceived inability on the part of police personnel, but because of possible conflicts in the image which the public might have of police functions. There was some feeling that a county health office might be a more suitable location. The question of whether the suicide prevention center might provide this function in multi-center cities was considered to be a loaded question, and "anything is possible" was the reaction expressed by the group members.

In terms of what type of personnel might be used in a telephone answering service, it was felt that the most important factor was the training of the personnel--it did not matter whether they were professional, law enforcement, non-professional, or even commercial, provided they were carefully trained for the job to be done.

In exploring the possibility that other methods of communicating emergencies might be needed for social and ethnic groups which do not utilize the telephone, we very briefly touched upon the necessity of learning to utilize the natural gatekeepers of information. There are several kinds of persons to whom people in the community turn naturally with their problems, such as druggists, clergy, lawyers, general practitioners, police in some cases, nurses, quasi-political leaders, etc.

On the question of what functions might be assigned to the central answering service in addition to locating the scene of the emergency and bringing the caller and the proper source of help together, it was felt that the centralized service can collect information, and facilitate statistical or data keeping procedures. It can also offer the important advantage of centralized responsibility for followup. In this context we were thinking of what apparently is the practice in Atlanta.

(The second part of this report was presented by Mr. Haughton.)

As a quite peripheral issue, we discussed at some length the nature of the Comprehensive Community Mental Health Center concept, particularly around the two issues of accessibility and intervention. It is highly desirable that a Community Mental Health Center get as close to people in need as possible. For some people this may require a tremendous extension of the Center out into the community. In the case of an answering service where a person calls in, it may mean justifying repeated calls back to that person to make sure the crisis has been satisfactorily solved.

There is, however, the need for recognition of the right of the person not to be constantly bugged. It is the resolution of this very delicate balance between genuine accessibility of service and sufficient intervention strategy which produces a major conflict in program planning and operation. All too often agencies use the fear of impinging on a person's rights merely as an excuse for not really providing accessibility of service.

I would like to close by highlighting a point which has really been discussed this morning: "What comes first, the suicide prevention center or the comprehensive mental health center; the social worker, psychiatrist, etc.?" Sitting here, I thought of a little story we might close on. Some of you who have been in the Middle East are aware of the fact that as you go up into the interior of Greece or Israel or some other similar countries, you very often see a situation where a donkey is going along the road with a man sitting on his back; and walking behind the donkey is the man's wife with a big load on her head. A tourist in the Middle East this summer had traveled through Greece, Israel and down into the Sinai peninsula. He stopped someone in Tel Aviv and asked, "What's happened? I noticed a curious reversal of the old custom of the man on the donkey coming first, and the wife coming after. Everywhere I went I found the woman with a basket on her head coming first, and the man on the donkey coming after. What's the reason for this?" The native looked at him and said simply, "Mines!"

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* * * Summary of Concerns in the Group * * *

Prepared By

David Hines

A. Concept of the "Community"

1. What is the basic community? What is the essence of a community?
2. Is a community determined by size, ethnic factors, ecology, etc.?
3. What do the people to receive a "community" service identify as their community?
4. What is the relationship between communication patterns and the concept people have about their community?
5. What is the relationship between "catchment areas" and the real community?
6. Is the "catchment area" a meaningful unit at all?
7. Who should establish the "catchment area" boundaries? Should the federal government through NIMH define these areas?

8. What is the effect of community planning bodies in determining community divisions for services?

9. When decisions are made by community planners, isn't this, in effect, turning power over to local vested interest groups?

B. Accessibility of Emergency Services

1. Are the Comprehensive Emergency Services going to be equally accessible to all who need them?

2. Are there some psychological barriers to receiving services? What are they?

3. Are there some physical barriers to receiving services? What are they?

4. Would it be possible to allow treatment teams to go into certain areas of needs, e.g., slums, rural communities, etc.?

5. How can the availability of the service be made known throughout a community?

6. Do we think some people "need" a service because of imposing our particular value system on them?

C. The Use of Volunteer Personnel

1. What is the real value of using the volunteer?

2. Do volunteers help spread the word about the availability of a service?

3. What should volunteers be called? Is the term "non-professional" appropriate?

4. How should volunteers be trained for their work?

5. Will the training given to volunteers tend to make them lose contact with the community? Can this be avoided?

6. Who are the natural gatekeepers that people in communities turn to for help? Can they be utilized too?

D. Making the service Program Fit the Needs of the Community

1. How can mental health centers identify the people who need service?

2. Are our present clinical methods adequate to attack the problems of large communities?

3. Are traditional facilities so oriented that they shut out the community and limit the extent of their services?

4. Are service programs designed to help the people, or to protect the professionals?

E. Costs and Rewards of Coordinating Emergency Services

1. Won't each service have to give up some power and autonomy if it becomes a part of a coordinated system?

2. Is the present practice so bad that we should take such a step?

3. Will the government compel coordination of individual agencies?

4. What rewards can be offered to agencies to get their cooperation?

5. Is there some confusion between suicide prevention centers and the emergency service of mental health centers? Do some people think they are the same?

6. What agency should coordinate emergency services?

7. Are there vested interests which are pushing for particular agencies, such as suicide prevention centers, to have this role?

F. Image of the Emergency Service in the Community

1. Should suicide prevention centers be called crisis centers instead?

2. How can these centers avoid being known as psychiatric centers?

3. Is it possible to avoid a psychiatric-medical orientation to their programs?

4. How can emergency services be established without being run by psychiatrists?

5. Is it possible to enlist consultation and other support from psychiatry without turning the program over to psychiatrists?

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Epilogue

In opening the first Plenary Session of the Workshop, Louis Cohen observed that his major function as Chairman was to permit enough time to elapse so that the last few participants could arrive late without missing anything important. He proposed to perform this honorific duty by saying a few things which everyone had already learned long ago, and by introducing some individuals with whom the audience was already very well acquainted. The Workshop seemed to begin and end on something of the same note.

One cannot read the work group reports, especially the Chairman's Report Sections, just concluded without a feeling that some very well known and often experienced phenomena were being described. Yet, because they are so crucial to the success or failure of a group activity, it is worth making a few redundant comments about these everyday social behaviors.

We observed in the six work groups of this Workshop, six separate microcosmic examples of what happens when any task-oriented group is assembled. At this Workshop both the task and the consequences of the group activity were characterized by considerably less complexity and significance than those faced by groups which convene themselves to undertake the development and/or operation of a system for delivering emergency services in the real community. Some of the Workshop groups failed miserably at their task while others were quite successful. Likewise, some communities will succeed with their emergency mental health service, and others will fail. The group dynamics will be the same in both cases.

There are certain stages through which any group must pass systematically during the development of its own organization. Time was provided in the Work Group Schedule to accommodate this organization development, and the Chairmen were deliberately reminded (in a pre-Conference briefing) of the things they all knew about group process. Yet, it is always possible for those whose hidden agendas are self-seeking rather than group-oriented to cast a disruptive shadow on the proceedings.

A well functioning and successful group develops toward the achievement of its task in the following manner:

(1) Each member of the group must decide whether or not he is, in fact, a member of the group. (This requires an awareness on his part of the extent to which he wants to belong to the group, and the extent he feels other members will permit him to participate.)

(2) Each member of the group must decide where the control of the group is to reside. (This means he must determine how much control he wants for himself, how much he is willing to grant to each fellow member, and how much control each member will

grant him. Control over a group is not only a function of formal overt leadership, but--most importantly--resides as well in the power of permission to influence the thoughts and attention of the group.)

(3) Each member must discover the resources which are present in the group. (This can only occur if each member is given the opportunity to reveal his own potential contribution to the group, and to learn, via feedback, how valuable he is perceived to be in relation to various elements of the task.)

These first three steps comprise the "getting acquainted" stage of group organization. They relate solely to group process, and must be accomplished before any task-oriented activity can be effective. Then the ground rules must be established.

(4) The group must define its purpose, and set forth explicitly what its goal is to be. (This step points up that the group can not assume anything about itself in the beginning. Rather, it must explore even the most basic issue: "Why are we together.")

(5) The group must determine the policies which will govern its behavior as it seeks to accomplish the purpose determined in the previous step. (The policies are general statements of intent, each of which may allow for a variety of specific alternative behaviors during the task implementation phases of group action.)

(6) The group must establish the specific procedures which are to be followed by each of the group members in the completion of its task. (This is the stage when the group finally comes to grips with the crucial question: "How are we going to do whatever it is we are supposed to do?" It is unfortunately, and sometimes even disastrously, true that most task groups actually begin their work at this point.)

(7) The group begins to develop its produce, or to complete its assigned or chosen task. (Only after these six stages of developing its own organization are the group members sufficiently well acquainted with one another, and with their own ground rules, to begin the work on their raison d' etre.)

The reader need only recall a few personal experiences in task groups in his own community in order to recognize instances when each of the six organizational steps was omitted by one or more group members. Perhaps it will also be evident how having spent some valuable time at one or more of the steps might have altered the course or the consequences of the group. If this is so, then he will have cause to expect greater success and satisfaction in his next group experience if some of these principles can comprise at least a part of his control over and contribution to the group.

Returning to the six Work Groups as microcosmic demonstrations of task groups in general, we see evidence of success and failure due primarily to the way in which the first three "getting acquainted" steps were handled.

1. Several groups commented that their early efforts to establish working definitions met with frustration and failure. No one could make a meaningful distinction between suicide prevention, crisis intervention, and emergency mental health service. It seemed to be on everyone's mind, but despite the desire to conceptually structure the task, each group had other work to do first. In one group certain feelings between and about various professional disciplines had to be expressed openly. This out of the way, the group proceeded to function very effectively.

2. Several groups provided data relative to the discovery of resources within the group. Most significantly of all, one Chairman reported that some of his members became so zealous over their own ability to contribute to the group that they proceeded "to squelch" all of the non-professional or lesser-trained professional members. The result was that these people were not permitted to ask a great many questions which were on their minds, and the group was deprived of much relevant data about itself and its task. By contrast, another group reported that their membership discovered the existence of misperceptions and distortions in the roles they perceived for one another. They "really looked at the feelings about each other" and were able to move into an atmosphere of "open trust and communication."

Similarly, in still another group which also expressed their inter-disciplinary concerns, it was significant that one professional group was able to recognize its own limitations and deficiencies. One must conclude that in the latter group the representatives of this discipline were made sufficiently comfortable and confident to discover the degree of their own resources without fear of intimidation. They remained as effective members of an effective group.

3. The seriously disrupted group also demonstrated that when members are not permitted adequate opportunity to explore the control issues, or to discover resources (especially their own in each case), they quickly recycle to the question of their own membership in the group. In this case, the Chairman reported, "we noticed people kept walking out, and didn't come back." Later, in the second session, they found the ranks thinned out considerably.

Another group which reported problems with its interpersonal processes discovered that their membership "quit early and had no desire to get back together." By contrast a third group which had essentially the same membership (but had taken time to explore their feelings about one another) also did not reconvene, but the Chairman reported a "feeling that they wanted to."

On the other hand, one may remain physically present, but at the same time elect not to become a part of the group. This occurs not only when a person abstains from participation in the group, but also when he refuses to acknowledge that a new group exists apart from all other groups of which he may feel himself a member. Two groups reported that they were especially bothered by the variety of different professional people who engaged in the usual "professional fence guarding and jealousy." One group handled this by feeling "forced to retreat to our traditional stances." They were essentially unable to form a new group wherein they would be required to develop a new identity role, or position of influence.

4. Control issues were apparent as major problems in several of the groups. In the groups which did not adequately explore their resources, it was largely because the prior step of deciding control issues had not been completed. Generally it was the inter-disciplinary control problem which predominated. In one group, however, it was a power struggle between representatives of State mental health authorities and citizens from local community groups. There was even some effort to project the blame for this onto the higher level of control--the federal government which is seen to hold ultimate control, that of funding.

This Work Group, probably more than all of the others, demonstrated what tends to happen most often in the real-life planning of our community mental health services. It is a problem area which begs for attention and resolution in the mental health field, since all levels of local, state, and federal government must function effectively. However, in this Workshop and in the world at large, this was a source of dissatisfaction and inefficiency within a group which had an important task to perform.

The behavioral phenomena demonstrated in these Work Groups are not new to most people who attended this Workshop. They are certainly not new to the mental health professionals who engage freely in them. Thus, we end as we began, by pointing out what everyone already knows, in the hope that those who are still to come in with their plans for community emergency services will not have missed anything which might increase the probability of their success.

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